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# HOMEOPATHIC JOURNAL

OF

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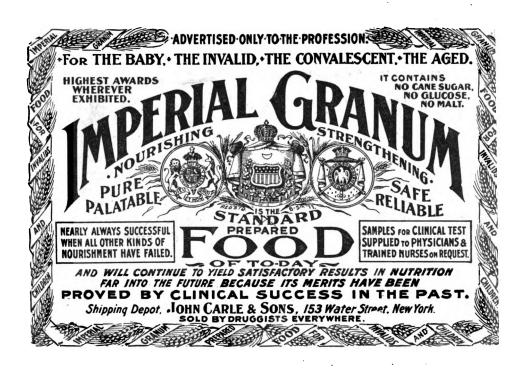
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Iulv, 1898.

Vol. XX.

#### BACKWARD DISPLACEMENTS OF THE UTERUS.

O. S. RUNNELS, A.M., M.D., INDIANAPOLIS.

Read before the American Institute of Homeopathy, June, 1898.

Retroversion of the uterus implies permanent dislocation backward with the axis of the body and the axis of the cervix essentially identical. Retroflexion denotes the permanent backward dislocation of the fundus, the cervix remaining in situ or participating in retroversion, the axes of the two parts forming an angle. In rare combinations retroversion with anteflexion or anteversion with retroflexion may coexist. The degree of backward dislocation is always a matter of relativity, and with the woman in the upright position is greater as the axis approaches the horizontal. Retroversion and retroflexion have intimate relationship, the former being usually a transitory condition originating the latter. It must not be understood that every retroflexion has retroversion as an antecedent, but that it is very frequently the case and that the two conditions have common causation. Practically they are found to coexist in many cases and must receive conjoint consideration. Whether it be retroversion, retroflexion or retroversio-flexio, matters little so far as etiology and principles of treatment are concerned.

Uterine position has wide latitude within normal limits. Situated between organs subject to distension and collapse, the uterus may be pushed forward or backward through a space of several inches as the frequent daily needs require. It may rise and fall to an equal or greater extent as is shown by sneezing, tenesmus, the genupectoral position and respiration. Its lateral mobility, while not so great, is yet marked and rotary motion is in some degree possible. Having no solid foundation upon which to rest, and being suspended in midpelvis by guy ropes and attachments more or less elastic, it may disport itself as a trapeze performer in executing any movement within its physical capabilities. Whether it rise or fall, lie prone or decubitus, traverse with its fundus an anteroposterior arc of sixty degrees, or make obeisance in its flexions to any point of the compass, is of small consequence so long as it shows its ability to regain and maintain itself. The positions assumed may be regarded even as anomalous, but so long as the uterus is able to return spontaneously to its normal position after the transient cause of the deviation has ceased to operate, it cannot be charged with displacement.

Uterine displacement cannot be diagnosed in the clinical sense until the deviation from the normal has become more or less stable. There must be limitation of automatic movement, prolonged departure from normal position and inability to maintain that position when regained to fulfill the requirement. In displacement passive movement may be in no sense circumscribed, the uterus may remain even abnormally movable, but active and independent exercise is more or less suspended, self adjustment is impeded and normal ability thwarted.

Uterine displacement, therefore, implies the embarrassment or obstruction of definite normal movement and the suspension in part or whole of normal ability. The play of forces incident to normal exercise has been disturbed and the equipoise lost. Natural prowess no longer obtains, an enervated and toneless organ is encountered and forces rule that dominate all passive bodies—I mean particularly the force of gravity. Especially is this true of all backward displacements of the uterus inasmuch as the consideration must embrace not only the weight of the helpless decubitus uterus, but the superimposed bowels pressing down upon its anterior surface, instead of forward upon its dorsum as in the normal position.

Backward displacement may be evoked primarily by any cause which may induce intensification of intra-abdominal pressure. Lifting a heavy object, violent vomiting, prolonged coughing, a blow on the abdomen or a fall in which the sacrum receives the impact, may serve as the initial. Even an habitually distended bladder may impinge upon the uterus so continuously as to engender permanent displacement. But while incidents of this character may serve as direct cause, there is in each instance a predisposing cause or antecedent condition of the system that must be regarded as part of the problem. Incidents capable of serving as the cause direct are of daily occurrence in the life of every woman, but it is only in cases of enfeebled or crippled vitality that they prove effective. When the life forces are regnant, uterine ligaments—contractile tissues-like the drawn bow of the archer spring back the moment the pull is relinquished, obliterating all evidence of displacement. It is only in cases of mal-nutrition and enfeeblement that elasticity is impaired, that power to regain the erect is wanting and that the uterus continues to lie after it has fallen.

It is clear that a comprehensive grasp of the subject cannot be gained without considering the antecedent factors potent in the production of this anomaly. Rigid induction has disproven the opinion held for a long time by most gynecologists that the predisposing causes of retro-displacements in the majority of instances were chargeable to puerperal experiences; that inasmuch as most victims of the misfortune are found among those who have borne children, the causation was, therefore, due to some mal-performance during the puerperal state. Careful clinical study has shown that while the larger quota of such patients are thus found among post-parturients, the pelvic weakness and liability to displacement, if not the dis-

placement itself, was in evidence before the first pregnancy, and the deviation was established or re-established in the puerperium because the uterine attachments were in the beginning relaxed.

This is in accordance with the observation of Kustner, that uterine displacements, or the tendencies thereto, "have been carried over into the sexual life from the time of puberty and puerility;" and proves that errors of development underlie most, if not all, of the cases, and that malnutrition is the universal factor. While the argument in no sense belittles the agency and importance of the puerperal factor, it justly emphasizes the necessity of the early and full development of the female sexual organs. The partial or complete arrest of the development of the uterus and adnexa is present in our day to a most surprising extent. The number of girls who reach the age of twenty with sexual organs in an infantile or dwarfed state is alarmingly great. Whether this be due in our cramming educational process to the diversion of the nutrient bloodsupply from the pelvic organs to a precociously developed brain; to the metastatic influences of zymotic diseases during puberty; or to indiscretions due to ignorance or wilful disregard of menstrual demands, I cannot now discuss. I note the fact as a reason for more rigid censorship over those girls, especially who are contemplating marriage, and over all who in any way manifest sexual embarrassment or inability, or who give evidences of sympathetic disturbances. Enlightened thought on this subject demands that all girls shall be free from the handicap of sexual non-development before marriage is entered upon and whenever embarrassed functional evidences are announced. Motherhood should never be essayed by one possessed of organs wholly incapable of completing the act without extra hazard or catastrophe. Uteri and uterine attachments which ceased to grow at the age of thirteen or thereabouts, should not be allowed to attempt the responsibilities which are safely and easily discharged by organs of full maturity. To this effect there must be a recast of views upon the subject of early physical examination in all such cases. Invalid and markedly undeveloped girls must undergo the rigid scrutiny demanded in all such instances. They must be

the recipients of such remedial help as is afforded by the gynecological resources now developed. Their sexual help-lessness must be supplanted by that vigor and tone which is the birthright of every one and without which capability and the creditable discharge of normal function is an impossibility.

I have purposely dwelt upon this phase of the subject because I consider it to be the chief factor in the remedy of all utrine displacements. I mean (1), that the establishment and possession of such vigorous organic ability would be an effectual bar to the development and continuance of such forms of incompetency before the advent of child-bearing; (2), that it would insure freedom from most of the perils of parturition evidenced by the well-known train of sequelæ, and, (3), that no cure of uterine malposition can be attained without regainment of normal vitality-both local and general. Wisely directed treatment, therefore, must in the first place anticipate the effects of the force of gravity upon a helpless organ by insuring the proper development of that organ; it must by prophylaxis hedge against the possibility of uterine and adnexal disability; it must see to it that every young woman is possessed of her full complement of life-energy, both local and general. I say the work of the gynecologist properly begins before the announcement of uterine instability; and is, ideally, of the order of prevention rather than patchwork.

Unfortunately this wise exercise of our knowledge is too rarely permitted. The faulty practice now is to wait till the weakness is engendered; to withhold help till mal-position has become stable. It is the up-hill work of reform; it is the regainment and re-establishment of energy lost that is, for the most part, called for in these days.

Coming from the abstract to the concrete, let us enter the clinical arena and deal with conditions rather than theories. Here is a girl under twenty, who is complaining of menstrual irregularities. The menstrual discharge is wanting; is too scanty of profuse, or is voided with great pain. She is, perhaps, constipated, a poor eater and has bad digestion. She has neurasthenia and faints away with or without provocation. She may be a consumer of slate pencils, chalk, plaster or other earthy matter, and is more or less incompetent mentally as

well as physically. A reasonable course of medication. calisthenics, reform of school duties and, perhaps, residence in health resorts, has been tried without permanent benefit. Before much time is squandered in fruitless effort of this kind she should be anesthetized and examination made of her clitoris, vagina, uterus, ovaries and rectum. Clitoral adhesions should be broken up, stenoses of sphincters overcome, papillæ of urethra, vagina or rectum removed, as well as every other occasion of sympathetic irritation. The diminutive uterus—displaced or not-must have rapid and thorough dilitation; the endometrium freed from all traces of vegetation, and the uterine muscle aroused from its dormancy by the induction of "mock labor." This should be accomplished by means of uterine packing with aseptic gauze continued through several hours or until nature makes protest in a slight rise of temperature, say from one to three degrees. The object accomplished by this latter step is the quickened and enlarged circulation of uterine vessels and a consequent better nutrient blood-supply to the starved part. Of course the treatment by divulsion and packing must be dependent upon the absence of acute inflammatory conditions in uterus and adnexa as well as all other contraindications. But her sexual forces must be freed from all thralldom and aroused to energy by methods simulating the normal and mature exercise. Such an embarrassed girl, I say, should never be allowed to reach conception or be forced to acquire uterine development after a possible impregnation.

It is remarkable how responsive nature is to such effort particularly through the first half of the child-bearing cycle. Development and growth of retarded female sexual organs is attainable in most cases at any age under thirty years, and while increase to normal standards at a later period is more problematical or wholly impossible, the removal of all occasion of sympathetic irritability is followed by such physical calm as is compatible with good health.

Whenever retro-displacements have been acquired in the nulliparous state regardless of age, the foregoing regime is applicable, subject always to such modifications as may be dictated by the morbid conditions present in the given case. Inflammations within and around the uterus should be over-

come, resultant adhesions absorbed or loosened up and tubal or ovarian degenerations ruled out before the employment of the radical measures here outlined. It must be remembered that a long decline of vital energy may have preceded your effort at cure; that uterine ligaments may have been under tension in such degree and for such time as to have acquired undue length and wholly to have lost elastic tone, and that a long directed effort may be called for in the re-acquirement of health conditions. To this end there must be persistent employment of the properly selected internal remedy; the uterus must be kept in right position for a sufficient time by wool tampon or other properly adjusted mechanical support, and every adjuvant utilized that will favor this accomplishment. Even then it may be ascertained that the elastic tone is irreclaimable, the ligaments and connective tissues are persistently lax and elongated, and that surgical shortening may be necessary.

Whenever retro-displacement has been acquired by the woman after parturition, the requirements of treatment are in many respects identical with those found necessary with the nulliparous, but may have in addition many new features. While the development of the puerile uterus has been accomplished in a measure by means of gestation, the parturient act has been inadequately performed and extensions and additional burdens have been imposed upon the state of pre-existent weakness. Cervical laceration, retained placental fragment or endo-metritis may have thwarted the performance of involution, and subinvolution of the uterus and its ligaments may have remained. In addition, the vaginal and perineal supports may have been weakened or swept away by rupture, thus obliterating all the restraint and sustained force of the pelvic floor. Under such circumstances the abnormally heavy uterus inadequately tethered by its lax and subinvoluted ligaments, like a top-heavy balloon, falls helpless and enters upon its course of descent. Prolapse is next in order and full procidentia a matter only of time. It is good fortune, indeed, if, in all this embarrassment, sepsis has not been superimposed and the ravages of inflammation are not an additional complication; or, if the cell-life in uterus or ovaries has not been diverted in its embarrassed activity into the evolution of cyst or fibroid, or other exhibition of hampered life exercise. In any event successful treatment is dependent upon the fullest comprehension of the facts and the probable employment of a wide range of remedial measures. The sole object being to establish or re-establish normal life ability all factors acting as a hindrance to this accomplishment must have abatement. Subinvolution, cicatrices, broken vaginal or perineal supports, perimetric or adnexal adhesions and all adnexal diseases or degenerations must be proven not to exist, if stability of normal uterine position is to be maintained.

Coincident with all this and of equal import with it in the etiological process, is the rectal factor. All gynecology must be a failure in greater or less degree that does not comprehend rectal pathology. Uterine morbidity, almost without exception, is attended by rectal morbidity. They go hand in hand, always a pair of them, and the ability to exhaust the general life force and make the individual affected a physical bankrupt, is as pronounced in the one case as in the other, and very effective when working together. It is sympathetic nervous irritation in both cases and the phenomena are identical so far as expression and significance are concerned.

From personal observation I am convinced that rectal morbidity is the leader of the procession in point of time; that it may, and usually does, originate in babyhood or early childhood, and that its enervating effects are operative long before the first impulses to quickened life are perceptible in the female sexual organs. Consequently I do not hesitate to believe that rectal morbidity plays a very large part in the causation of sexual non-development as well as in the production and continuation of the neurasthenia so pronounced in every gynecological case.

But after all has been done to rectify retro-displacements of the uterus that the nutritional problem can suggest, many persistent and wholly intractable cases will remain. The normal tone of uterine muscle and ligaments in such cases is irreclaimable by any and every kind of procedure. The uterus persists in resuming the decubitus whenever external support is withdrawn: or protests with pain and intolerance to the employment of any mechanical device or scaffolding, designed for its support. These are the cases that have tested the resources of gynecology to the utmost limit and have defied successful treatment till times the most recent.

To meet such emergency the operations of Alexander and Schroeder were introduced. In the one case the slack of the ligaments is overcome by the excision of enough of the ligaments to make them sufficiently short; in the other, the utility of the ligaments is disregarded by making the fundus uteri fast to the anterior abdominal wall. It is almost a double decade since the introduction of these measures to the profession, and from that day to this experiences have been ripening with great rapidity. Some advocate almost the exclusive use of the one or the other procedure, but the consensus of opinion is to the effect that each operation has a definite field not encroaching upon the other, and that they can be combined to advantage as occasion demands. Alexander's operation consists in opening the inguinal canal on either side of the pubes, picking up the round ligaments of the uterus, drawing them out as far as they will come readily, cutting off the surplus and fixing the ligamentary stumps in the inguinal canal. By this procedure the fundus uteri is approximated more or less to the anterior abdominal wall; the uterine body is lifted out of the pelvis and the retro-displacement is converted into anteversion. This operation is applicable only when absolute mobility of the uterus and appendages is assured, and when the latter are in an entirely healthy condition. Many operators have experienced great difficulty in being able always to find the round ligaments, and it has been proven that these ligaments are in anatomical fault sometimes in making deflections in their attachments to Poupart's ligament, or other tissues, rather than to the inguinal ring. In other instances the ligaments have proven too frail to bear the pull made upon them and have broken, thus defeating the endeavor; while in yet other instances hernia has been left as a legacy of bad technique. The great merit of the operation consists in the simplicity of its performance in the average case, and in the avoidance of entering the peritoneal cavity. The results in properly selected cases are most gratifying, the uterus retaining its regained position with greater tenacity than antecedently, or than under average conditions, and this notwithstanding the effects of following pregnancies. The field of this operation, however, as originally proposed, is greatly circumscribed by the fact that retrodeviations without adnexal lesions are rare, and that the correction of the former without overcoming the latter is sure to end in dissatisfaction to all. It has been proven that apparent mobility of a uterus retrodisplaced does not disprove the presence of embarrassing adhesions when the uterus is carried forward, and that such mobility does not imply freedom from adnexal disease. Persistent painful retrodeviation proves at once the existence of limited mobility as well as adnexal disease. Ovarian prolapse and ovarian degeneration have long been regarded as synonymous terms—the chronically prolapsed ovary being invariably degenerated.

Inasmuch, therefore, as the reposition of the uterus to its normal position without removal also of the adnexal lesions is followed so frequently by incomplete cure, open exploration of the pelvic cavity is frequently necessary. After the manual liberation of adhesions and the reclamation of diseased appendages by conservative surgery, or their ablation, if degenerate beyond redemption, the uterus by the ventral operation is fixed to abdominal wall by permanent sutures. The manifest advantage of this operation consists in the acquirement of exact knowledge concerning the intrapelvic condition by ocular demonstration and the opportunity to deal with the abnormality present, as the condition demands. The object of the operation is not merely to secure the adhesion of the fundus to the abdominal wall, but to see to it that all conditions capable of aborting the success of the procedure are overcome. The success attending ventro-fixation, hysterorrhaphy or hysteropexy, as the operation of Schroeder is indiscriminately called, has been of a very high order. Under certain contingencies ventro-fixation cannot be supplanted by any other procedure. The objections to the operations, however, are: that it involves the performance of coeliotomy and the dangers incident thereto; that the fixation thus made of the uterine fundus is an embarrassment in case of pregnancy, abortion thereafter being a frequent result, and that the aperture left by

the operation between uterus and bladder is another opportunity for intestinal strangulation. While the validity of the first objection has been robbed almost of its force by the perfection of surgical tecnique, it cannot be denied that pregnancy has suffered interruption by the enforced impairment of uterine mobility, and that wayward intestines have migrated through and been caught in the foramen of Schroeder. For these reasons the trend of opinion is away from the practice of uterine immobilization, especially during possibility of child-bearing; or, at best, that it must be an operation of second choice.

Modifications of the Alexander operation have been made that overcome the objections to its employment in the exceptional cases, as follows: After abdominal section and the removal of adhesions and the correction of adnexal abnormalities, the round ligaments are shortened by doubling each upon itself and stitching it thus doubled to the anterior wall of the abdomen or uterus. The resultant adhesions, while insuring permanent shortening, add greatly to the strength of the ligaments and the permanency of the results. In case of rupture of the ligament in the primary method of Alexander, or the inability of the operator to find the ligaments the suprapubic route and the intrapelvic method of shortening is justifiable.

In greater favor, however, is the approach to the pelvic peritoneum by way of vaginal section. The ease with which adhesions can be broken up and the success attending minor surgery of adnexa through vaginal section makes the latter the route of election in perhaps the majority of instances. Opening is made into the peritoneum either through the vesicouterine fold, or the recto-uterine fold, and ample proof gained as to the exact condition. Existent adhesions can be broken up; morbid or wholly degenerate adnexa can be patched or removed and frequently the round ligaments can be doubled upon themselves, as before described, leaving nothing to be remedied. Or if ligamentary shortening be not thus satisfactorily attainable per vaginam, the hindrances to the successful performance of an original Alexander's operation can be removed. The minimum risk to the patient thus gained, together with the feasibility and success of the procedure in

a very large percentage of the cases in which Alexander's operation would otherwise be excluded, make the latter operation as amended the operation most widely applicable at the present time.

The endeavors to secure anteflexion in retrodisplacements by means of various operations to secure wider and firmer utero-vesical attachment have proven impracticable and therefore unpopular. Of this order was the operation of Schucking, which consisted in entering the peritoneal cavity between uterus and bladder, carrying a silk thread through the uterine canal and fundus and back through the peritoneal opening into the vagina, and then tying the ends of the thread so as to enforce anteflexion till the formation of adhesions. rodt's operation is based on a similar mechanical principle, but differs in its execution. Opening is made to the peritoneum through the anterior vaginal pouch—as in Schucking's operation—the bladder pushed up, the fundus brought down into the aperture made by the section and held there by strong stitches passed through the vaginal walls. In both operations an immobilized anteflected uterus is substituted for a uterus, having backward displacement, but more or less mobility. It has been proven to be ventrofixation by another route, and has occasioned abortion to pregnancy in like manner.

Yet other conditions may be present that will not be remedied by any of the foregoing procedures. Tears in the tissue of the fundus uteri during parturition amounting almost to rupture of that organ may be followed by cicatrices of equal importance to the more common expressions of that kind in the cervix; diminutive multiple fibroids may so occupy the uterine body as to defy successful conservative removal or the retrodeviation may prove to be an incident in the companion problem of procidentia. In all such cases uterine ablation may be the shortest road to cure—may be, in fact, the only road to cure.

An irredeemable or degenerate uterus either before or after climaxis is without efficiency from any standpoint of observation. Its day of usefulness being wholly past, its retention should not be tolerated, or certainly should not depend upon reasons of mere sentiment.

So long as uterine efficiency is reclaimable, effort should continue in the hope of attaining the desired result; but when failure has attended the fullest exhibition of gynecological resource, and a hypersensitive and hopelessly involved uterus acts as a drag upon the woman's existence, there should be no hesitation about amputation.

To recapitulate: Retroversion with allied conditions is dependent upon non-development primarily, and malnutrition secondarily, of the pelvic sexual organs, and is resultant from a more or less prolonged decline of local and general vitality. The onset of this decline and waste of vitality is due to causes which may be grouped in two grand divisions: First, those operative antecendently to and in conjunction with physical development, and second, those operative at the time of, and subsequent to, parturition. This classification, however, is purely arbitrary and must not obscure in any case the basal fact that malnutrition of uterus and adnexa is the gist of the whole matter. This is but another way of saying that inasmuch as the uterus with its adnexa is but an intmiate part of an organic union, the malnutrition must be general as well as special, and may be general before it is special. Whether, however, it is first general and then special, or vice versa, does not change the requisition that malnutrition must be banished and normal conditions of life be established. The hungry child must be fed; good blood in sufficient quantity-facilities of growth to full stature—must be provided, and the incubus of non-development banished in the local sense as well as in the general. In any event the essay of maternity should not be made except with organs mature and capable.

If, however, such blunder has been made and a train of parturient sequelæ results, the effort to banish malnutrition must still go on; the aim to remove the incubi to a vigorous blood circulation and to re-establish the tone of good health is still pressing. Polychrest remedies, both medical and surgical, may be called for and time almost without limit demanded in the acquisition. Even then failure to establish or restore never-possessed or lost energy may result, and the ablation of organs, that menace life, that render health acquirement impossible and that are in fact wholly worthless, be demanded.

After many years of patient endeavor to solve the problems of backward displacements of the uterus, I am convinced that the aggregate of gynecological knowledge may be required in the attainment of the desired object in all cases, and that the gynecologist capable of dealing with its many formulas must be master of his art.



#### AUTO-INFECTION.

BY HENRY EDWIN SPALDING, M.D., BOSTON.

Read before the American Institute of Homeopathy, June, 1898.

The knowledge gained during the last decade concerning sepsis, and the application of that knowledge to the discovery and use of means for attaining and maintaining asepsis, has very greatly lessened the dangers of parturition. This has been again and again proven by comparing voluminous statistics before the days of antiseptic proceedings with those of the last few years, when sepsis has been generally guarded against. These favorable results are shown not only in institutional but also in domiciliary practice. I will not detail them here, as to do so would be only rehearsing an old, oft-told tale. Such grand results must not for a moment be lost sight of, but it is quite possible that the intoxication of success may be leading the profession to ignore some factors in the problem that must be counted if its solution shall give, as a result, perfect asepsis.

Not long since, in a lecture before a society of Boston ladies devoted to the consideration of physiological subjects, a young physician, filled to overflowing with the latest lecture-room pabulum, made a statement like this: "With to-day's knowledge of sepsis and the use of antiseptics, the very simple fact that the patient has puerperal septicemia convicts the attending physician of ignorance or neglect in a degree that should disqualify him for the practice of medicine." Of course, such a broad statement had, for the moment, its intended effect, and each woman mentally condemned this or that previously esteemed physician to the shades of desuetude. The chances are that when that young man meets the stern realities of obstetrical experience, the scriptural rebuke, "By your words ye are condemned," will rudely awaken him to see the absurd self-assurance that led to their use.

In bringing before you the subject of auto-infection, I would not be understood as discrediting in the least the wonderful results attained by the careful and effective use of antiseptic measures. I believe they are of inestimable value and cannot be ignored in any degree. I would go steps farther. While guarding the citadel of vitality against the entrance of a foreign foe, I would closely scrutinize the forces within, lest they open the portals of the assailants, or themselves in concealed mutiny traitorously destroy it.

Since toxemia in parturition is subject to the same laws as toxemia in surgery, we may very properly look to surgical authorities and experiences for light in dealing with this subject. Roswell Park says: "One of the greatest advances made in recent pathology has been the establishment of the fact that a great many of the morbid conditions from which the human race suffers are those due to causes arising entirely from within their own systems." Again, "I have long maintained that many surgical patients present forms of blood poisoning in which the poison has not proceeded from the wound."

Indeed, Genzmer and Volkman have asserted that there is such a thing as an aseptic surgical fever, due to the absorbtion of the products of normal tissue changes at the site of injury.

Dr. E. S. Jackson says: "We cannot expect to classify the various types of puerperal fevers until we can classify the various causative bacteria." He insists that because the vagina contains these bacteria before labor, we must recognize auto-infection as one of the causes. Among the many others who recognize the fact of auto-infection are Barnes, in a recent paper before the British Medical Society; Henroty, Barton, C. Hirst and Lusk.

Within the limits prescribed to papers in this convention, it is impossible to do more than briefly mention some of the most conspicuous facts pertaining to the subject.

The intestinal tract may be the source of systemic infection from

- 1. Unexpelled normal excremetitious matters.
- 2. Ptomaines.
- 3. Pathogenic bacilli.

That fecal matter contains substances of marked toxic powers has been amply proven by practical observation, and experimental research has shown that excretive and other undefined substances that await investigation are highly toxic. The toxicity of putrid matter stands undoubted, and yet an extract made of putrid matter is much less toxic than one made of fecal matter. The products of liver action are in greater part

eliminated through the intestinal canal. By his liver man forms enough poison in eight hours to kill him. These substances unduly detained in the intestinal canal are taken up by the absorbents and produce systemic poisoning, which may be not only serious in itself, but so weakens the vitality that the resistance to the assaults of toxic germs that may find their way through some open door is ineffectual, and sapremia, septicemia, or even pyemia may result.

The more acute form of intestinal toxemia arising from ptomaines or leucomaines, violent in itself, destroys systemic resistance to attacks of pyogenetic and other bacilli.

What more interests us here is the fact that the intestinal canal, in its entire length, swarms with bacteria of various kinds, which, under favoring conditions, raid upon the interior of the body. A local injury or simple inflammation may furnish a lodging place for these wandering organisms and establish a focus of infective inflammation which shall result in a systemic toxemia. Park says: "The ease with which the colon bacillus passes through the coats of the intestine which has been in the slightest degree disturbed or abraded is remarkable." "Without the existence of recognizable lesions, these bacteria sometimes emigrate, and perhaps enter the circulation."

If this condition is an ever-present menace to successful results in general surgery, it must be much more so in parturition. Here the resisting powers are often weakened by disturbed renal hepatic functions; the blood is so changed by gestation that at other times the condition might be termed pathological; and then follows the still further devitalization from exhaustion incident to labor, and we have conditions most favorable to the invasion of toxic germs. Add to this an intestinal toxemia producing a condition of sapremia, as above demonstrated, and we have a condition most favorable for the working of pathogenetic bacilli. It needs only such a contusion or abrasion of the rectal surfaces as often attend difficult deliveries to invite a condition of fully developed septicemia or pyemia

Septic infection sometimes manifests itself before the onset of labor. I cannot better describe this condition than by briefly

reporting an illustrative case from my private practice. Mrs. ---- had passed through gestation in a perfectly normal manner, as she had done in two previous pregnancies. The day of expected delivery was at hand. For twenty-four hours there had been a free, bloody leucorrhea. She had no pains. and she seemed in perfect health. She was awakened during the night with a severe chill, intense headache, pains all over and nausea. Temperature immediately arose to 103.5°, pulse The chill was followed by free perspiration, without, however, giving much relief. Her face was dark, congested and expressionless, except from the look of suffering. least effort of moving or being moved increased her discomfort. In about twelve hours labor pains came on, and fortunately she had a quick delivery. She flowed freely, but not to a great excess. The child was robust, and a careful examination of the placenta showed no signs of degeneration or other abnormality. In two days the fever had practically gone, and she went through an uneventful recovery. In the absence of any renal or systemic disturbances, I believe that here was a case of sapremia, or possible septicemia, the bacilli having entered through the vaginal canal to the cervix, where the process of dilatation had caused a breach of continuity of surface, as indicated by the free bloody discharge during the previous hours.

Most modern bacteriologists, like Bumm and Boderlein, claim that auto-infection can develop nothing more than a condition of sapremia, and that pathogenetic cocci are not found in the healthy vagina or cervix. They acknowledge, however, that as soon as the normal healthy vaginal secretion becomes alkaline, which may easily happen from admixture with the cervical secretions, it becomes a most favorable culture medium for pyogenic staphylococci and streptococci, and auto-infection becomes possible. On the other hand, Mironow, with others, claims to have demonstrated the presence of streptococci and staphylococci in the vaginæ of healthy pregnant and puerperal women. When we remember that there are absolutely few healthy vaginæ, we must recognize the danger from this source.

Remy claims that the meconium is a source of puerperal in-

fection. If it became mixed with the liquor amnii, the uterine cavity will be soiled. This fluid decomposes rapidly. On the other hand, it is generally claimed that the meconium in the new-born child is free from bacteria, but rapidly becomes infected by them. This being the case, it is not the meconium that is the offending cause, but it offers a fertile soil for the growth of toxic germs.

The most frequent site of septic infection in the puerperium is doubtless the intra-uterine surface represented by the area of placental attachment. The uterine sinuses are plugged by thrombi, which, if the uterus be not firmly contracted, may extend well into the uterine musculosa. Thrombi are of themselves innocuous, and are cast away with other uterine detritus in the form of lochiæ. But let putrefaction take place from contact with pyogenic bacilli, by absorbtion we get a condition of sapremia, or the bacilli themselves with the decomposing clot may be taken from the sinuses into the circulation, giving complete septicemia or pyemia. The pyogenic cocci that thus infect the thrombi may come from the vagina, from some supperating disease, like cancer of the uterus or its appendages, and most frequently of all from a pus tube. In the absence of statistical proofs, I believe that 90 per cent of all cases of autoinfection come from this source, and that of all cases of puerperal septicemia, a large portion are infected in like manner.

When we consider how large a part of the work of gynecologists is the treatment of pyosalpinx, or troubles in which this forms a conspicuous part, we can readily comprehend the dangers from this source. The astounding statement is made that in New York city and France 80 per cent of the men have at some period of life been affected with gonorrhea, and 90 per cent so afflicted remain uncured; and of women who married these victims of gonorrhea, scarcely 10 per cent remained well. This means that many of these unfortunate wives go through the stages of vaginitis, cervicitis and endometritis, and the inflammation then enters the fallopian tubes and pyosalpinx results. If both tubes are involved, conception will not likely occur. If, however, but one tube is affected, conception is possible, and she is exposed to one of the greatest dangers of parturition.

#### DIETETICS IN OBSTETRIC PRACTICE.

C. A. WEIRICK, M.D., CHICAGO.

Read before the American Institute of Homeopathy, June, 1898.

Pregnancy is a normal condition. The development of the fœtus in utero, its birth, and the subsequent formation of milk in the mamma of the mother for its sustenance are physiological acts. It is a mistake to speak of the date of parturition as the time the woman will be sick. The maintenance of the health of the woman if she be well, its restoration if she be ill, and the highest development of the child are the objects sought from the physician. All treatment, including dietetic, is for the purpose of attaining them. Any diet that impairs the health of the mother or hinders the development of the child should be avoided. It would be superfluous to state such a self-evident truth were it not that a diet is recommended that has for its purpose the amelioration of the pain and shortening the duration of labor by preventing ossification of the bones of the head. An insufficient quantity of inorganic food will impair the nutrition of mother and fœtus. An excess of salts will derange digestion, but not promote ossification.

If during pregnancy the mother be in a normal condition the same kind of food that is proper for her when not pregnant should be given, if ill the same diet for similar affections occurring as at other times. For example, did albuminuria occur the proteids should be avoided or a minimum amount taken the same as were the woman not enciente. The woman's special attention should be called to the necessity of taking a sufficient quantity of water in twenty-four hours. The tendency is to take too little rather than too much. If she be a tea-drinker derangements of the digestive organs are more liable to occur than were she to abstain from it. If accustomed to this beverage, and it is not advisable to discontinue its use, black tea is preferable to the green variety. The custom of adding carbonate of soda to neutralize the effect of the tannin will, in some cases, neutralize the hydro-chloric

acid of the stomach to such a degree as to impair gastric digestion.

Several years ago in a paper read at the Illinois Homeopathic State Association, I called attention to two classes of mothers. As subsequent observations confirm those previously made about them, and as diet is the most important factor in the management of one of these classes, it is within the scope of this paper to direct attention to them. In one class the mothers are languid, feeble, and more or less emaciated, both during gestation and lactation. Abortions and premature deliveries are common. Their children at birth and during lactation are plump, well nourished, vigorous and good. The mother does not understand why her child can be so good and feel so well when she is so miserable. If a mother without organic disease feels miserable during pregnancy she will almost invariably give birth to a child fitting the above description.

In the other class the conditions are reversed. The mother feels well, is strong and looks vigorous during gestation and lactation, the child at birth is of the puny, half-starved variety and does not thrive as long as it is dependent on the mother for sustenance. It whines, cries and has the reputation of being a cross baby simply because it has a normal appetite and makes the only protest it can against an insufficient diet.

In the brute creation the analogue of these two classes is found in domestic cattle. The dairy cattle corresponding to the first mentioned class, and the stock cattle, or the variety raised for beef producers rather than milk, to the second class. I am sure this statement will be corroborated by the observations of those who have lived in the country. The weak mothers digest their food which is not used to nourish their own bodies but that of the child in utero and to supply it after birth with an abundance of milk. The strong mothers digest their food and in addition apply it to their own nutrition at the expense of that of the child.

Only theories can be given in explanation of these facts, and hence not satisfactory. For the weak mothers most benefit is obtained by giving prepared food. Murdock's has produced the best success in strengthening the mother during

the periods of gestation and lactation without the least detriment to the child. In cases of this class who have previously been pregnant and shown their usual tendency to miscarry or have premature labor, it is the only treatment I have found that may be used with any reasonable degree of certainty and comfort to the patient. For the strong mothers having weak children there is no treatment, dietetic, hygienic or medical, that will help the child before its birth. Deprive the mother of sufficient quantity and quality of food and she suffers; give her any kind of food and she appropriates it to her own tissues. After the child is born the right course to pursue, and there is but one right course, is to resort partially or wholly to artificial feeding. The stereotyped advice that the mother's milk is the best food is just as pernicious for this class of cases as that which prescribes milk in all cases of typhoid fever.

Special mention should be made of nausea, constipation and albuminuria because they are so liable to occur during pregnancy. Nausea, when strictly the nausea of pregnancy, cannot be either controlled or palliated by diet. When it occurs at certain periods of the day food should be avoided at that time. When it is continuous the food should be predigested and given to the patient while in a recumbent position. In some of these cases coffee without cream or sugar will be tolerated. In severe, or long continued nausea, the following is advised: Partially predigested milk or gruel, malted milk, somatose, or dry, nicely toasted bread. Food should be given every three hours. If the case be so severe that it will be ejected soon after ingestion, nutrient enemata should be given every four to six hours. Partially pancreatinized milk, beef and white of egg may be used with success. Avoid the use of fats and starches in the enema, and observe the same care to prevent the expulsion of the food and irritation of the rectum as in other conditions requiring rectal alimentation. But this reflex symptom must be controlled by other than dietetic measures.

Constipation, so common in women, is usually aggravated during pregnancy. I believe much harm, often serious, is done by permitting this condition to continue. It causes malaise and elevation of temperature, the latter most frequently during the post-partum period. For seven or eight months of

pregnancy it can best be met by observance of such dietetic regulations as are commonly advised for constipation. But during the last month or two of the term, when there is a mechanical factor in the producing cause, it is best to give less quantity of food having large residue and more having a smaller amount. When this condition exists a full quantity of fluids, seventy to eighty ounces, should be taken in twenty-four hours. A tumbler of water in which one-half teaspoonful table salt has been dissolved, taken in the morning at least half an hour before breakfast, will help cure the case of constipation. The water, without the salt taken at that time, is also effective. Corn-meal made into mush, corn cakes or corn bread, also parched corn, should be added to the other foods eaten to meet this trouble.

I agree with those physicians who believe that the urine of a pregnant woman should be occasionally examined for albumen, and when it has once been found in any case the amount of proteids given should be reduced and maintained at a minimum even though it disappear. There is a predisposition to its recurrence. If severe, the diet should be exclusively milk, to be continued for two weeks after labor; if not severe, a small proportion of meat may be taken, also fruit and vegetables. Alcoholic beverages, all of them, should be prohibited.

The unaccountable craving for some special article of food that is met in some pregnant women should be gratified to the extent of taking a reasonable amount. I do not wish to be understood as advising that a craving for albumenoids in those cases having nephritis, nor for carbohydrates in those having diabetes, nor in any other condition when the desire is manifestly due to some disease in which the article craved is clearly contra-indicated.

During labor, if it be of short duration and the woman strong, food should not be given. If the woman be in a weakened condition, or if the labor be more than seven hours' duration, liquid food should be taken. Coffee, beef broth and milk are the best. The first two are stimulating in their effect, without any reaction. This advice, if followed, conserves the strength, lessens the danger of post-partum hemorrhage, and enables the patient to better endure the necessary assistance

in difficult labors, and the immediate repair of lacerations. The ingestion of food during labor will relieve some cases of nausea.

The old theory that eating after labor will produce fever is erroneous. During the lying-in period the woman should receive food. She has much to do at this time. The discharge of lochia, repair of lacerations, beginning of uterine involution, change of colostrum to milk secretion in sufficient quantity and quality to meet the necessities of the child are some of the physical demands which require for their accomplishment a force that is best obtained from a sufficient supply of proper food.

Marked beneficial results have been obtained by giving dry toast and a small cup of coffee or tea half an hour after completion of labor, especially if the patient be exhausted, is the benefit realized by herself. For the first twenty-four hours after delivery the food should be largely liquid, broth, beef tea, milk toast, soft boiled eggs and plenty of pure water. Then if she be in a normal condition solid food sufficient to meet her desires should be allowed. If puerperal fever develops, the diet should be liquid, given according to rules for feeding in fevers.

During the nursing period all classes of food should be taken in the same proportion as in other healthful conditions. The quantity and quality of the milk is best maintained by keeping the system in a normal state, and not by the ingestion of any one article of diet or class of food. Of course, the food should be pure, taken regularly and thoroughly masticated. Alcoholic beverages should not be allowed, they do not increase the quantity of milk any more than does water. The latter will not only increase the quantity but also the solid constituents of the milk.

I repeat, in closing, that it should be borne in mind that pregnancy, parturition, and lactation are not diseased conditions, and the woman should not be made ill by a restricted or abnormal dietary. If she has any disease the diet suitable for it, when the above conditions do not exist, should be given.

#### ACUTE INANITION.

BY A. M. LINN, M.D., DES MOINES, IA.

Read before the American Institute of Homeopathy, June, 1898.

Inanition means starvation. Starvation is usually accepted as indicating death from want of food, while inanition applies to an inability to assimilate the food taken. The non-assimilation may be due either to the poor quality of food or to the inability of the system to appropriate the requisite nourishment to sustain itself. Of these two causes of inanition the former is much more frequent. In crowded tenements in the poorer sections of cities the eye of the physician often falls upon the bony, impoverished child starving for want of proper nourishment. The innutritive quality of the mother's milk may be due either to her own ill health, mental or physical, or to overwork, or faulty self-nutrition. The result is inevitable; the infant becomes weak and scrawny from lack in quantity or deterioration in quality of its nourishment. Children born in such surroundings, where comforts are few and the bare necessities of life often wanting, are especially liable to inanition. They want sufficient vitality to begin the vegetative process or soon cease to struggle. Feeble nature makes but a weak, ineffectual effort at nourishment and unless supported the child soon dies of inanition.

#### SYMPTOMATOLOGY.

Acute inanition means quick starvation. It may supervene upon a pre-existing mal-nutrition or as the result of exhaustion from disease. It is much more frequent among infants and does not occur often after the first year of life. Few marked symtoms manifest themselves in the course of inanition. The emaciation may not be remarked until it has made much progress. The observant mother may have noted only that the child is ill. He may be petulant, or, more frequently, listless. There is either a fair appetite or an indifference to food. Sometimes the child will take no food, or, at most, but an ounce or two in the twenty-four hours; an amount totally inadequate to support the system. Vomiting does not often occur. Diarrhea is a more frequent symptom, and the un-

digested character of the evacuations may help to a diagnosis of poor assimilation. Less frequently constipation obtains. The child soon manifests an aged appearance, the skin wrinkles, the eyes become glazed and sunken, the thermometer reveals a sub-normal temperature, the heart's action is rapid and rather feeble. The whole picture presented by the symptoms indicates a threatened early collapse of the vital forces.

Many of the cases coming under your care result from want of assimilation of food. The abrupt or partial failure to take food is usually preceded by a period of gradual decline. It may come as a sequel to marasmus. Few cases will be found that are wantonly starved. The decline in weight and in strength continues for a time, when nature, somewhat exhausted, abandons the struggle; the child refuses the proffered food or takes so little that it is utterly inadequate to sustain life. Or, it may result in this as in ordinary cases of starvation. The first hours the pangs of hunger are very severe, but gradually diminish toward a time of comparative indifference. The exhausted nerves of the vegetative system issue no urgent call for nourishment. The system reposes in a condition of comparative quietude and indifference to food. Unless some unusual stimulant is applied the case progresses to an early fatal termination. One case of this type in my practice was saved by the use of predigested peptonoids. (Fairchild Bros. & Foster.)

Another form of inanition has been noted in a lying-in institute for unfortunates of which the writer has charge. In this normal appetite is present at any time; the system seems to crave no food. The child will neither nurse nor take an adequate amount of food in any form. These cases, conceived in sin, gestated in sorrow, and born in an atmosphere of grief, seem to want the ordinary appetite of a new-born child. They grow weaker and rapidly lose in weight and strength and shortly die. Others seem to thrive for a time; but if from some cause a change of food is made they begin to fail, and even a copious supply of the previous nourishment fails to check their decline. No available means seems capable of preventing the rapid progress of emaciation and they soon pass away.

# PATHOLOGY.

No definite pathological changes have been noted as resulting from inanition. Indeed, it is more definitely described as a suspension of function than as a pathological lesion. Either as a result of poor quality of food or too scant a quantity, or both, the impoverished nerve centers controlling nutrition cease performing their allotted function. The suspended operation of the impoverished nerves means a cessation of the vegetative function. Life continues as long as the involuntary movements of respiration and circulation, spurred by the systemic call for oxygen, can compel them to act. When no longer able to respond to these appeals the spark of life goes out, leaving no pathological change of sufficient moment to attract attention. Of course there is great emaciation and loss of weight, but these are the results and not the cause of the disease. The intestinal villi undergo no considerable change. Beneath a high power lens the nerve cells of the brain will be found shrunken and shrivelled, plainly revealing their inability to generate the required nerve force to stimulate vital activity sufficient to maintain life. The child dies not because of structural changes, but because of suspended function.

#### DIAGNOSIS.

No pathognomonic symptom marks this disease. According to Holt, it is "distinguished from mal-nutrition by its greater severity and from marasmus by its more acute character." The following diagnostic features are present in most cases: The rapid emaciation, partial or complete, loss of appetite, quickened pulse, feeble heart's action, coldness of body, loose, wrinkled skin, subnormal temperature, anxious expression, sunken and glassy eyes, bowels loose or costive, etc. With these symptoms in one's mind, varying in gravity from light to severe, according as the case in its inception or approaching dissolution, one is not likely to make an error in diagnosis.

#### TREATMENT.

The treatment of inanition is not usually attended with a full measure of success. The powers of assimilation seem to weaken the general progress of the decline and demand most energetic measures to awaken them to renewed activity. When insufficient food is the cause the means of relief is easily determined. A supply of nutritious food, gradually increa ed in quantity, is both the means of relief and essential to the cure of the disease. When the nourishment is faulty in quality the disease is more difficult of determination and of remedy. In the case of your little patient the time is short and "whatever is done it were well done if it were done quickly." No time can be spared for doubtful experiments. A few brief hours, or days at most, and the sands of life will run past that critical point where recovery is possible. Every effort should be made to secure a wet nurse for the patient. Failing this, diluted milk should be used, well peptonized, and given at rather frequent intervals. At one instance in the writer's practice success was obtained from the use of malted milk, and in another from peptonized milk. Soups and broths are generally worse than useless. It is a well-known fact that the body is more quickly robbed of its vitality in a cold atmosphere. Careful attention, therefore, should be given to maintaining the temperature of the body by the use of warm applications; also sponging the body frequently and applying moist compresses may be helpful. Where vomiting is persistent, or there is a refusal to take sufficient liquids, life may be prolonged by the use of salt water enema. Holt records one case in which he succeeded in saving life by means of gavage. For this purpose malted or predigested milk should be used. Numerous expedients may be resorted to in order to accomplish the desired purpose.

## REMEDIES.

While the adjuvant treatment is important, the remedial treatment must not be neglected. No one can name the critical point of decline beyond which remedies cannot awaken a reaction. It is a proverb: "Where there is life there is hope;" and while the child breathes we should hold with tenacious grip to the spark of life. We may be as successful as we hope and more so than we expect.

The following named remedies may be consulted in the treatment of acute anemia: Sulphur, arsenicum, lachesis, calcarea-carb., china, nux-vomica, phosphorus, iodine, rhustox and thuya.

# CERTAIN ETHICAL PHASES OF GYNECOLOGICAL PRACTICE.

SHELDON LEAVITT, M.D., CHICAGO.

Read before the American Institute of Homeopathy, June, 1898.

In every department of practice one early encounters responsibilities of a trying nature and is required to determine rules of conduct which involve ethical questions. It is for this very reason that medical and surgical practice should not be taken up by those in whom cupidity is the ruling passion, whose moral principles are not well settled and whose sensibilities are not morally keen.

In the popular mind the surgeon is a man of intrepidity and courage, and for these qualities to be admired; but a man also lacking in sympathy and that gentleness of spirit which should characterize one whose duty it is to inflict the severest physical suffering with a view to the betterment of the sufferer. It is true that the practice of surgery is in some sense a hardening process. The surgeon, as a natural result of familiarity with scenes of suffering and death, ceases to be profoundly moved by the emotions which often stir the ordinary heart to its very depths; but experience does not necessarily make of him a monster of cruelty, or a human butcher, as he is sometimes hysterically called, though we regret to say it sometimes does. That a surgeon ever becomes cruel in outward appearance, or even at heart, should be a cause of deep regret on the part of those whose sensibilities retain a modicum of pristine sensibility, and whose motives, despite the seductive influences surrounding him, remain of the purer and better kind.

The physician and surgeon, confronted as he is at the very outset of his career, before he has given ethical questions due consideration, is apt to arrive at unwise conclusions, especially if deficient in moral virility. Your chairman is not disposed to set up any unattainable moral standards; but to consider before you certain points of conduct, with respect to some of which he admits there is ample room for more than one honest opinion. There are among us many who are inclined pharisaically to observe the letter, rather than the spirit, of ethical obligation,

ignoring the truth that moral principles rest not upon arbitrary requirements and mere conventionalities, but upon considerations of human interest and the ultimate good of mankind. Conscience, when unwarped by prejudice and blunted by disregard, prompts to one action and dissuades from another solely because the indicated line of conduct leads with unswerving certainty to the largest good for all concerned. According as we follow such dictation is individual and general evolution enabled to work out its beneficent results.

But now to the particulars. A moral responsibility which rests with much weight upon the conscientious operator, is that concerning his personal fitness to do well the surgical work required. The same sense of responsibility is felt by the conscientious physician with respect to his ability to serve well, by his medicines, the interests of his patient; but in medicine the real responsibility involved is not so great, owing to the fact that the possibilities of serious harm are not so pronounced as in surgery. The question: Am I well equipped, both in point of knowledge and mechanical skill, faithfully to serve the best interest of the confiding patient before me? is one which the operator ought seriously to propound to himself, and be able affirmatively to answer, before he puts a knife to the case. In order to be forearmed he should consider, with wise forethought, possible complications, and map out with scrupulous precision the available resources with which to meet them. In the opinion of your chairman there is a great deficiency of regard accorded these important considerations even by men of honest intentions. Not long ago your chairman was called some distance out of the city to do a uterine curetting for a practitioner of our school of medicine, and, in conversation concerning surgical work in general, this man of medicine who had felt himself incompetent to manage a case so simple in character as that which had just received our attention, expressed perfect confidence in his ability to do deft abdominal surgery. There is no intention to inveigh against the moral right of any one, however inexperienced, to undertake work for which he is theoretically qualified, since every surgeon must gradually wear away his novitiate characteristics. One is enabled to develop true skill only through experience, and these strictures are directed against those only who hold human health and life as commodities to be turned over to the tender mercies of a successful bidder, without regard to his qualifications as a trustworthy conservator; or who feel that to shrink from any undertaking, no matter how dangerous or difficult, is an indication of weakness. As a result of practice, it is true we acquire manipulative skill, and the confidence that affords so material aid is the actual doing of operative work; but we have no right to the necessary experience unless we have made ourselves familiar with each step of the procedure through clinical observation and faithful study. Anything short of this makes us mere jugglers.

Then there is the reckless surgeon. He may be well informed in regard to methods and general technique, and possess wonderful manipulative skill, but he is a reckless, impatient soul, hurried and goaded by undisciplined and refractory impulses. He jumps to conslusions, makes off-hand diagnoses; prides himself on short operations, and is little disturbed by unfavorable results. Comet-like he blazes in the heavens, and comet-like, fades before he reaches life's meridian. He fills, it maybe, a most important place in surgical evolution, and yet is the object of many a summons from the bar of moral justice.

For the brilliant achievements of such a one we feel a justifiable admiration, because the force of genius always commands it; but what shall we say of a surgeon of the oldschool who laughs at new methods, depreciates the value of strict antiseptic precautions, and is little moved from his old and well-beaten ways by the achievements of up-to-date surgery, however grand? It is true that he is sometimes constrained so far to countenance certain innovations as to commend them publicly; but his precepts and practice are widely divergent. When he goes to his work, after hastily preparing his hands, you see blue in the subungal spaces, and he avails himself of the most convenient aid, in the heat of an emergency, without questioning the assistant's preparedness. His percentage of loss is heavy, at which he is distressed, vet by it he is not reformed. What about this man's moral responsibilities?

But gynecology is not all surgery, and there are ethical lines reticulating the medical, as well as the surgical, phases of practice among women, that we shall do well to study somewhat in detail.

The gynecologist is subject to peculiar temptations which appeal to his cupidity, and among them we may reckon the opportunity to reap a harvest from women whose lively fancy and vivid imagination have made them mental invalids. Many of the women's ailments, as we all know, have their tap root in the mind, and such subjects accordingly become an easy prey to the unscrupulous doctor who has a dominant regard for filthy lucre. Women are apt to be controlled by their intuitions while their prejudices and prepossessions are not easily overcome, so that great tact and consummate discretion are indispensable to the attainment of the best results of treatment. They will not often tolerate raillery, or even pleasantry, directed at their supposed ailments, especially by a strange physician, and the part of wisdom is to handle their delusions in a gentle but firm manner, conceding to them by implication, some claims, of the genuineness of which we are not fully convinced, and giving to each symptom its due weight. It follows that a truly honest physician or surgeon may find it wise to resort to drugs, or even operative measures, to set in motion curative mental impulses and impressions in those who have become possessed by the idea that their only relief is to be found in operative measures, that nothing short of an operation is likely to effect a cure; while others have such an antipathy to surgery, and so great a fear of it, that its mere mention is sufficient to precipitate them into a state of direct mental and physical chaos. But to make traffic of mental weaknesses and morbid fears, instead of putting forth honest endeavors to correct them, is unworthy one who poses as a benefactor.

Should unmarried women be subject to thorough pelvic exploration? This question is often asked, and to it various answers are given. Some would have us make no examination except as a dernier ressort; but they are mainly those who undertake the management of all sorts of pelvic trouble without proper investigation, laying no emphasis upon the sur-

passing advantage derivable from physical exploration, and possessing no adequate knowledge of pelvic pathology.

It is alleged that besides the reduction of a girl's modesty resulting from such an investigation, currents of thought are directed to the generative sphere which may prove prejudicial to the health and morals of the subject. But have we not reason to believe that possible lesions, excluded by the results of an examination, or recognized and cured, had they been left to luxuriate in a sensitive subject would likely have produced pernicious results far outweighing those apt to be engendered by a well-conducted examination? The truth is there would be fewer physical wrecks among our girls if careful examinations were more common; for there are many remedial ailments, which, when neglected, work disaster to physical health and vigor.

And, again, when it is found that there are conditions which make vaginal exploration and intra-vaginal medication desirable, should we not set aside, if necessary, a prudish anxiety to preserve "the proofs of virginity" in order that the immediate diagnostic demands may be fully met? A young woman whose character is above reproach, and whose mien and bearing are those of a virtuous maiden, never requires physical evidence to convince a husband who is worth the having that her integrity is above question; while, on the contrary, a woman of wanton manners would not be able to establish her essential virtue by the possession of an intact hymen of the most elaborate form and dimensions.

The ideal physician has not yet been actualized in life. The best of us have our weaknesses. We are all bound more or less closely by conventionalities, and feel circumscribed by current habits of thinking and living. It cannot well be otherwise; but, as guardian of the physical and mental health of the community, we should resist the impulse toward servile conformity, and settle questions of morals, as well as those of contingent occurrences, for ourselves. There are many evils in every community, injurious to mental, moral and physical health, which merit rebuke. One of them is the marriage of young men and women whose children are apt to take on the physical weaknesses, and follow the vital tendencies, of their

polluted or degenerate parents. There are men all about us bearing in their organisms taints which are more to be feared than death; and yet we interpose no word of serious objection when we see them about to enter into conjugal relations with lovely and confiding girls, the fountains of whose purity, or the health of whose offspring will be exposed to the foulest contamination.

There is no denying that it is far easier to preach than to practice, for the truth is demonstrated in the lives of all, those of the medical fraternity forming no exception. Doctors ought to be wiser in matters pertaining to heredity than are the laity, but it is plain that they are not; or, to take a more charitable view of their attainments, they give most unwise heed to knowledge which they possess. But let us throw over them the cloak of charity, for love is a blind goddess, and the mesalliances among our brethren show that she is a blind leader of the blind. Let us pray that they may not all fall into the ditch.

The prevention of pregnancy is a question which has agitated physicians and social scientists to a phenomenal degree. It is a subject in which many feel a conscientious interest, and concerning which they recognize a profound responsibility. Laws have been framed which make it a misdemeanor to offer advice looking to the prevention of conception, or to furnish the means by which such a purpose is accomplished. Such laws are undoubtedly wise in their intention, and yet all of us are well aware that cases are not infrequent, wherein, as lovers of humanity, and as conscientious men and women, we feel a sense of obligation to aid in the prevention of conception by the best advice of which we are capable. It is all well enough to say that nature ought to be allowed to take its course, and that a kind providence will doubtless overrule apparent evil and out of it all evolve a high order of results. But with strains of insanity and other disorders in the subject; with dipsomania and continual intoxication in the husband, or tuberculosis and syphilis in the mother, united with a strength of impulse which makes neither party able to control the sexual relations, have we not a moral, if not a legal, right to extend the aid of our advice to prevent

procreation? These people should practice self-restraint, and perhaps they do; but total abstinence is quite another thing, and is hardly to be expected. Besides, physical and mental depression is liable to follow protracted absque marito in the conjugal state. The study of social science cannot wisely be separated from that of physiology and pathology, and any attempt to do so is certain to result in an incompleteness which cannot fail to render rules of conduct and proposed plans for the betterment of social conditions relatively partial and unpractical.

Your chairman presents no plea for leniency of judgment upon these Malthusian ideas, for he is strengthened by the conviction that they represent the consensus of professional opinion.

This leads us to a consideration of the larger question of abortion, in which gynecologists, as well as obstetricians, should feel a deep interest. We cannot too strongly condemn the practice in general, whether undertaken by women upon themselves, or by unscrupulous physicians whose cupidity has acquired a mastery. It is one of the crying evils of the fin-desiecle, and is bringing upon those who are subjects of it numerous and serious ailments, as we gynecologists stand ready to testify. But what is astonishing is the general apathy concerning it. Notwithstanding the heinous nature of the offense in the eves of God and men, we hear few voices publicly raised in condemnation. Women share each others' confidences and become mutual instructors, treating the subject so lightly as to break down moral sentiment and overcome conscientious scruples to a lamentable degree. The clergy, while not hesitating to raise its voice against other evils, appears to regard this as a forbidden topic; and even physicians are not always disposed to condemn the act in the terms which its evil nature deserves.

But there are features of this question of abortion which many are disposed to overlook, and which the law fails to recognize, well worth serious consideration. It is conceded that for the protection of maternal life the physician is justified in inducing premature expulsion of the product of conception; but are there not other considerations which should be regarded as sufficient justification of the act? Your chairman will not attempt to recite them, but as an example he will point to a pregnancy in which the parents are criminals or drunkards.

It should be added that there is no intention to suggest larger liberty for the individual physician in the practice of abortion, but rather the wisdom of a provision, in the interest of society, for wider discretion to be accorded an established medical council, or a definite number of physicians assembled to consider the case. Such a suggestion some of our wise and prudent may regard as a mere fantastic conceit; but when we see the sins of parents so often visited upon their innocent progeny, we cannot but feel that further effort should be made to limit and circumscribe such deplorable results of uncontrollable indulgence.

It may be that a more practical and less objectionable method of controlling such conditions is to be found in the establishment of a marriage license board, made up of physicians who shall refuse permission to marry in all instances of mental, moral and physical disqualification.

Another pertinent suggestion, and one which your chairman has long sought an opportunity publicly to make, is that of castration of all criminals, both male and female, who are found guilty of grave offenses. There is undoubted heredity in criminal impulses, and society has a right to demand protection from its baneful influences.

While the foregoing are matters in which medical men and womer: in general should manifest a deep interest, they are of special concern to gynecologists, and for this reason they have been here introduced. But we come now to consider a few specific questions of an ethical import concerning the practice of gynetic surgery.

First of all let us bring up the question of capital operations for the possible relief of nervous symptoms. It has been quite uniformly conceded that there are few conditions not menacing to life which justify invasion of the peritoneal cavity. At the same time we cannot but recognize a disposition of surgeons to extend the benefits of their superb science and art to the re-

lief of conditions not necessarily inimical to life, but decidedly so to health and comfort, even though it involve entering the sacred precincts of the peritoneum. It cannot be denied that a protracted and helpless state of invalidism, especially when accompanied by pain, renders life hardly worth living, and forces one to the adoption of possible means for relief even at the expense of some risk to its continuance. This avenue of escape for the valetudinarian has been much widened of late, and has been more inviting by reason of the reduced mortality resulting from asepsis and improved technique. Under proper safeguards the impulse is entitled to moderate encouragement, though it must be confessed that there is danger of the movement carrying us to an unwise extreme. Your chairman cheerfully admits that his own convictions have undergone considerable change during the past two or three years, in the face of which he still accounts himself a conservative surgeon.

Another question over which a great deal of sentiment has been shown is that of removal of the ovaries from unmarried women. There is no doubt that about the generative sphere gather the strongest forces which make for connubial peace and happiness. All true sentiment between the sexes springs from it, and it is manifestly unfair to womankind unnecessarily to mutilate or ablate the sexual organs. Removal of the ovaries has probably been practiced to an unnecessary degree; and yet, with all the recklessness that has been charged to it, we have reason to believe that the operation has a surplusage of good to its credit. Some lives have been lost, and in a few suffering has been increased; yet on the whole it is probable that these evils have been more than counterbalanced by the renewed vigor and restored peace of mind brought to the many. Let us remember that all surgical measures find their justification in the preponderance of good which they bring to suffering humanity, and the aid they give to the forces which are steadily elevating and ennobling the race.

There are many who take a narrow physical view of such questions, exalting mere sensual gratification above the essentials of true living. We should not reckon it as woman's chief function to be pleased and pleasing plaything of selfish husband, or to co-operate to the maximum in populating a sphere

already teeming with human life. But then we have no good reason to suppose that the relief of a woman from the agonizing disturbances growing ont of imperfectly developed genitalia, even at the expense of their aglation, to so change her womanly nature, or so injure her instincts, as to disqualify her for discharging the duties, bearing the responsibilities and performing the delightful ministries of married life. And even should it cause her to enter into sexual relations with diminished zest, we are not hastily to infer that the sum total of human happiness would be thereby in the least reduced.

It is evident, notwithstanding the recently developed disposition to extirpate the uterus along with diseased appendages, that the surgical mind inclines more and more to what may be reasonably regarded as conservative surgery. To such a degree does this disposition characterize some operators, that, rather than deprive a woman, even though married and already the mother of two or three children, of the organs essential to reproduction, as, for example, the ovaries in their entirety, they prefer to compromise to a serious degree the patient's chance of complete restoration to health by a resection of the ovaries, rather than destroy the possibility of further childbearing by complete excision. The surgeon does not have every case committed fully to his discretion, and hence may be limited to a one-sided operation. But when left to conduct a case according to his own judgment, he should remember that moral considerations may dictate most radical measures. In making up a verdict under these conditions the patient's constitution, both mental and physical, is entitled to close scrutiny and much weight. While, in a given instance, doubt of the advisability of complete removal of both ovaries may be reasonably entertained, provided the patient possesses a constitution disclosing none of the evidences of morbidity so often witnessed, in another case, presenting the same operative requirements, but with the ear-marks of serious dyscrasiæ or mental aberration, there is left but little room for honest doubt. Women long to become mothers, but we know that many of them are mentally, morally or physically unfitted for maternity, and in the wav of such ought to be thrown every rational hindrance of fruitbearing by those who are in some sense the constituted guardians of society.

Your chairman doubts not that he will be regarded by some as lacking in regard for ordinary conventionalities; but he is not disposed to forestall such opinion by either qualification or denial. It is but fair, however, that he be permitted to repeat what has already been implied, that the intent herein is chiefly to interrogate thoughtful minds, and present ethical problems deemed by him highly important, but much neglected, with a view to betterment of present conditions. The beaten path is not always the best one, and popular opinion is not always the wisest. "Whoso would be a man," says Emerson, "must be a noncomformist." The medical man, the medical woman, are projected into the very midst of moral questions requiring delicate treatment, deliberate consideration and wise decision; and they are to be congratulated who meet such responsibilities in an earnest and honest spirit, and bear them to wise and happy issues.



# ANEMIA AND MARASMUS.

BY B. F. BAILEY, M.D., LINCOLN, NEB.

Read before the American Institute of Homeopathy, June, 1898.

We have been thankful that the term scrofula, that cloak which for so many years "covered a multitude of sins," has become practically obsolete. The attempt, however, to define more intelligently and in better keeping with scientific knowledge has not been and is not without its difficulties. That the many manifestations of the formerly so-called scrofulous diathesis are due to malnutrition can hardly be controverted. That the first evidences of this malnutrition are found in the blood is probable, but a hematic differentiation, so that we may be able to tell what change in the blood leads to anemia, what to rachitis, what to marasmus, what to this pathological form, and what to that, is as yet impossible. The term anemia, hitherto signifying a deprivation or impoverishment of the blood, may now be considered to also refer to changed conditions of the blood, and may be assumed in some of its forms to be the probable initial field of the numerous diseases of malnutrition.

It is true there are certain diseases which we can diagnose from the study of the blood, which are the diseases of so-called primary anemia. There are others which in turn impoverish the blood and are called the cause of secondary anemia. Thus if I be allowed, I will assume that primary anemia results in certain diseases, whereas secondary anemia is the result of certain diseases. For example, the diseases of primary anemia are, first, chlorosis, with its normal or nearly normal number of erythrocytes, though they may be abnormal in shape (poikilocytes), or unusually large (macrocytes), or at times, perchance preternaturally small (microcytes), but always deficient in the coloring matter of the blood, hemoglobin. An increased number of leucocytes (leucocytosis) is not common. In brief, not a condition of decreased red blood corpuscles (erythrocytes) or increased white corpuscles (leucocytes), but of deficient hemoglobin.

Second. We have as a primary anemia, pernicious anemia, in which there is a very great diminution of erythrocytes, a

moderate diminution of leucocytes and an increase of hemoglobin. The large red blood corpuscles with fragmented nuclei megalablasts are very common in this disease.

Third. Anemia infantum, or pseudo-leukemia—a rare form with a lessened number of erythrocytes (oligocythemia), lessened hemoglobin (oligochromenia), an increased number of white corpuscles, or leucocytes (eucocytosis)—considerable enlargement of the spleen, little change in size of liver, with an enlargement of the lymphatic glands, which is general and not excessive.

Fourth. Leukemia. This disease presents two forms: the splenic and myelogonous, or spleno-myelogonous, and the lymphatic. In both forms there is a marked increase in the leucocytes and diminution in the erythrocytes. It is not alone that the leucocytes are increased, but the myelocytes or large mononuclear neutrophiles are in abundance in the spleno-myelogonous type; while the small mononuclear leucocytes, or lymphrocytes, are absent. In the lymphatic type the leucocytes are not so largely increased, but the lymphocytes are increased proportionately, making, instead of as normally, 25 to 50 per cent of the entire leucocyti count sometimes as high as 90 per cent of the total count, and the myelocytes found normally in the marrow of the long bones and abnormally in large per cent in the spleno-myenogonous types are rarely if ever found in the lymphatic type.

The secondary anemia, that is, the anemiæ that are in a general way considered to be the result of previous conditions, and not the cause of them, are usually due to some of the following conditions, although it is probably true that all diseased conditions result in a greater or less degree in anemia. The special causes of anemia are hemorrhages, acute infectious diseases, syphilis, intestinal affections, tuberculosis, etc. Most authorities also mention as causes of anemia thachites neoplasius, diseases of the skin and bones. I must, however, take exception to this view, and until proven in error shall believe that existing evidence indicates the changes of blood found in these diseases to partake more of cause than effect. To generalize, the so-called secondary anemia should be discussed as effects or sequelæ of the diseases which cause them.

Of the primary anemia, chlorosis proper is rare in children. Some doubt if it ever occurs, as, for instance, Weiss; while others, like Henrod, are equally insistent that it does occur. It is probable that it does occur in a modified form. Progressive pernicious anemia is usually fatal, except in the one type of the disease which has been caused by intestinal parasites and hence was a secondary, not primary disease, recovery ensuing after the expulsion of these parasites, namely, the anchylostoma duodenalis and the cothriocephalus latur. All attempts to prove the disease the result of micrococci have thus far failed.

Anemia infantum, pseudo-leukemia, is very fatal in its progress either from the course of the disease itself or from intercurrent diseases. Leukemia, too, is held to be a most fatal disease, the spleno-myelogonous type perchance offers the most real hope of a prolonged life, while the lymphatic may offer the most apparent hope. I believe, however, up to this time, the lymphatic type had been universally fatal.

Marasmus is now written of under the name of infantile atrophy, under the technical supposition that marasmus being a symptomatic term it should not be used as designatory of a disease; but, again, I fail under the best writers and authorities to find infantile atrophy anything more in its meaning or its elucidation of the subject than the older term marasmus. Pardon me if I here register a most emphatic plea against the continual increase of terms and terminologies which, so far as rtility is concerned, add nothing to our lore except a chance for the display of a seeming knowledge and a wearisome labyrinth for the student.

In this disease we have extreme atrophy, wasting of muscular tissue, without evident disease. The symptoms are those of gradual starvation. Actual lessening of weight of body, of muscular tissue, with sometimes slight enlargement of some of the lymphatic glands usually present, increased excretions from the bowels, though the skin is commonly dry, stools quite apt to be loose, vomiting may occur, though it is not common, patient is usually fretful and moans as if from indescribable suffering or weakness. Temperature may be normal or slightly increased or decreased. Rotch says: "It is probably due to a

vice of absorption." One of the most difficult things, and yet perhaps one of the greatest and most useful, to learn to say, is, "I don't know." Evidently Rotch had not learned this, for he expressed little else in his "vice of absorption." It is commonly admitted that the cause of marasmus is unknown. To be sure, it often seems to be due to some grave intestinal affection, but we find ourselves unable to distinguish in any demonstrable particular the difference between two similar intestinal conditions, the one benign in its results, while the other is marasmatic in its trend.

The diagnosis is not always easy as between tuberculosis and so-called atrophy, several writers stating that the symptoms presented are exactly the same, even to a similar elevation of temperature, post-mortem examination or recovery only solving the problem.

It is a very intractable disease, but not by any means hope-After all, what have we? A few demonstrable facts of histology, and our clinical memories and theories deduced therefrom. No one has been able to do better than this. Hence we too may be pardoned if we dare in the light of our knowledge and experience to theorize in a simple way. Throughout all nature the inorganic salts seem to have a wonderful office. In one place their office seems to be chemical in another catalytic. Not always as easy to demonstrate the positive office of their presence as the dissolution resulting from their absence. Maragliano advanced the theory that serum deficient in these organic salts was destructive to the erythrocytes or red blood corpuscles. If perchance this be true, we have then to consider whether a serum barren of inorganic salts is destructive from a toxicity or whether it is only negatively destructive from a lack of cellular nutritive. We know that in the serum there is a predominance of sodium salts over potassium salts; also an advance of chlorides, but a scanty supply of phosphates. Now we know that these salts are the very ones that favor rapid absorption, and osmosis, and we may, consequently, believe they in this way favor active nutrition. Further, we know that when uric acid is most in evidence in the system it is often scant in the urine; and, therefore, it is but a reasonable proposition that in a normal condition of blood-serum the phosphates and proteids are rapidly taken up by the corpuscles; whereas with a minimum amount of the inorganic salts in the serum there is a tardy disappearance of the salts of the ailments and, hence, imperfect nutrition. To carry our argument still further the corpuscles of blood both contain as vital element of their composition a proteid matter of which nuclein is a prime factor, and nuclein is rich in phosphates. Without these phosphates the nutrition of the corpuscles cannot be efficient, and with imperfect corpuscles the general nutrition of the body must suffer from autointoxication, in that the activity of the lymphatic system is probably impaired by a lack of vitality of the white corpuscles. while the imperfect oxygenation resultant from weakened erythrocytes must prevent prompt disassimilation and rapid carrying away of debris. For instance, in the splenomyelogonous form of leukemia, we find a surplus of old cells, the myelocytus, while new ones are not forming; the balance is lost and we have an anemia cachectic in character, with the evident auto-intoxication which is found in all anemiæ. Again, in the lymphatic type of anemia we find the lymphocytes which we may with reason assume to be the younger corpuscles in abundance, while there is a drouth of the older form, and, hence, there is in the lymphatic system a rapid formation of embryonic tissue, not a neoplasm proper, but an embryonic hypertrophy. That I may not trespass or be tiresome, let us see in a few words what we may properly deduct from these assumed facts.

First. Inasmuch as we cannot find early pathological conditions in other parts, and inasmuch as in all cases of anemia, marasmus and malnutrition are to a greater or less extent evident, we may judicially deduce the theory that the seat of primary anemiæ and marasmus is in the primary laboratory of the body; the blood.

Second. Inasmuch as the processes of the body are largely chemical in character, the forces thereof being vital in origin instead of the manipulation of the chemist, it is but fair to presume that certain conditions and elements must be exact to bring certain results, otherwise we will have as in the more delicate work of the laboratory or of the electrical, an im-

perfect conclusion, and that this conclusion is certain to be imperfect unless the primal steps are exact.

Third. Admitting this to be true, yet it is often difficult to trace the error in the laboratory, and impossible in the human domain, but the difficulties only render it more imperative that we should adopt a reasonable hypothesis, and work it out to either a negative or positive conclusion, until we find by results that our hypothesis is a fact and that our unknown quantities can be named.

Fourth. Taking these assumptions together with experience for our authority we find in children that may present themselves for our care as anemics and marasmatics a small heart with vessels as large or larger in proportion than we find in health or in adults, a condition which in the adults in low tension of circulation, and a tendency to fatty degeneration and poor muscular and hematic nutrition, and a weakened power of assimilation of inorganic salts. In the adult this may be endured for a long time, because the firmer tissues of the body, as the bones, et cetera, are formed and are at least for a certain time, permanent. On the other hand in this type of child we find more formative cells but less fibrin and hemoglobin; thus a striving of nature under imperfect conditions to provide for the growth and nutrition of the child, resulting in rapid formations, but more rapid degenerations because of the formations of embryonic and other than mature types.

Accepting these theories, which at least to me seem reasonable, we are ready to consider how we may by treatment correct these errors in nutrition and growth. First strengthen the heart and blood vessels by careful massage and by the administration of the 2x of strychnia in doses of one-fourth drop morning and night. Second, correct the tardy assimilation by the administration of natrum phos., if there is evident acidity of the system; or of natrum mur. should the symptoms by their indications evidence a lack of chlorides; following these with calcarea phos., ferrum phos., kali phos., magnesia phos., or some of these nutritive remedies; remembering that Schuesslerism is but Homeopathy which Schuessler did not understand. That by administering these remedies we do not seek to supply the need, but to so correct the powers of assimi-

lation that when we supply the system with food rich in the needed salts, they may be properly appropriated and not hurried into the sluice-ways of nature.

Our foods in marasmus must be contrary to the usual formulæ; at first rather high in sugar, low in fat, and rather under than over in proteids. As strength increases fat may be increased as the system strengthens enough to dare its appropriation without injury. Many a case may rapidly benefit by adding to the milk a small quantity of calcarea phos. and magnesia phos., which renders the caseinogen of the milk more easily precipitated and digested. This being a nucleoproteid aids in the restoration of the proper ratio of nuclein of the corpuscles. In extreme cases it is wise to use in small doses as food, protonuclein; or where calcarea phos. fails though seemingly indicated, we may use the glycero-phosphate of lime, which is the nearest salt akin to that of the lichthium of the corpuscles and nervous system that we have, and which in my hands has given wonderful results in certain cases.

Do not forget in cases refusing after all aids to properly oxygenate the blood, to give teaspoonful doses of glycozone, which I can assure you has saved lives for me.

But though so large a subject, so small is space and time, that only a few thoughts have been jotted down. He who thinks and works must read between the lines.



## ECTOPIC GESTATION.

C. B. KINYON, M.D., ANN ARBOR, MICH.

Read before the American Institute of Homeopathy, June, 1898.

We have a right to assume that doctors are human, possessing the same love of fame that other mortals possess. This being true, we need not be at all surprised that many medical writers, teachers, practitioners and operators are inclined to emphasize the newer ideas. Putting forth their best endeavors, in contriving or discovering something new. Neglecting or overlooking the older, and oft-time well established, principles and methods.

This same element in human nature is responsible to a great extent for the present extreme tendency toward specialism in medicine.

Few are possessed with sufficient perseverance and pluck to fully prepare themselves so as to properly cover the whole field of medicine.

In this rushing, competing age, all feel that they must push for success at once. Hence they hasten to perfect themselves as best they may in one special line, failing to fully grasp the interdependence existing between diseases of the different parts of the system. The above general considerations being true, I have no apology to offer for bringing to your notice at this time the subject of ectopic gestation. For of all the obstetric complications which we may be called upon to meet, none presents a greater diversity of phenomena. No condition presents greater complications. None require more accurate diagnostic skill. None will test more fully all the powers of the attending physician. And what is more, there is no condition which proves more surely and more rapidly fatal, unless the right thing is done at the right time, and that time is necessarily short and comes very often without a moment's warning.

The Scriptures tell us that each generation grows weaker but wiser.

The fact that the present generation is weaker may perhaps

justify us in concluding that ectopic gestation occurs more frequently than formerly. For ectopic gestation does not take place in a strong and healthy woman. Or it may be that we doctors of this generation, being wiser, have reached a greater perfection in diagnosis, and thus it is more frequently discovered. Be this as it may, the fact remains that in the past thousands of women have died from ruptured ectopic gestation sazs whose death was attributed to peritonitis, to pelvic hematocele, or, perhaps, to heart failure. What a consolation it must be for some doctors to remember that their patients have hearts, and that hearts sometimes fail. Just a word at this point regarding hematocele.

During very recent years, a great change has taken place in the minds of our best thinkers, writers and operators regarding their opinion of the cause of pelvic hematocele. At least seventy-five per cent, and some put it as high as ninety per cent, of the cases of pelvic hematocele are due to ruptured gestation sacs.

This will not surprise us when we remember how early the blood vessels of the uterus increase in size. One of the most important of the fœtal appendages, the chorion, begins to form on the twelth day after impregnation of the ovum, and its villi form very soon thereafter. The capillary loops in these villi are quite large and bleed freely when ruptured. One other important fact is worthy of elaboration. The impregnated ovisac may rupture and severe hemorrhage follow before the naked eye can distinguish the sac. But the cells of these villi are readily distinguished by the microscope very early. Several cases have been operated upon and reported during the last year, or reported at time of autopsy, as the case might be, wherein the only positive evidence of ectopic gestation was found in the cells of these villi.

All other traces were absorbed or the rupture was too early for other tissues to be developed. We thus see that the microscope is not only of great value, but it is often our sole means of making a correct diagnosis in some cases of ectopic gestation. As it is only with the microscope that one can distinguish between the decidua of dysmemorrhea, the uterine decidua of ectopic gestation, without the chorionic villi, or the

uterine decidua of abortion with these villi present. With all the symptoms of pregnancy present, but no chorionic villi in the discharges from the uterus, we are justified in concluding that ectopic gestation is present. Of course our examination of the discharges must be thorough and exhaustive, but its conclusions are almost absolutely safe.

I have now given you the cue as to why it is possible for the recent observers to speak with such positiveness regarding the fact that ectopic gestation is the chief cause of hematocele.

The first clear description of hematocele was given by Nelation in 1850, but he did not give its true cause.

The first successful operation for ruptured tubal gestation was performed by Lawson Tait in 1883.

A third of a century during which the true cause of hematocele was not suspected.

Before then ectopic gestation was looked upon as a freak of nature and was very rarely diagnosed. We now know it to be very frequent indeed. It is generally conceded that all cases are primarily tubal. Abdominal pregnancy does not occur primarily, and it is very doubtful if the ovarian form does. The fecundated ovum may be located altogether in the tube, or it may be between the tube and ovary—tubo-ovarian—or it may be tubo-uterine. The tubal is by far the most common form. The tubo-ovarian is still in doubt, but some excellent authors claim that the ovum may be impregnated while resting in the fimbriated extremity of the tube.

Exudates and adhesions form around it and bind it to the ovary. But as this form cannot be distinguished during life it is not worth while to spend more time upon its discussion.

The tubo-uterine occurs in that portion of the tube embraced by the uterine wall. As this occurs so very seldom, I will dismiss it with few words. It does not rupture before the sixteenth to twentieth week, as the uterine walls are capable of distention and will resist rupture longer than the thin non-muscular walls of the tube. The products of conception may find their way into the uterine cavity, but, as a rule, rupture occurs into the abdominal cavity, and is rapidly fatal as the hemorrhage at that stage and in that location is simply fearful and hard to control, as you cannot reach the arteries in time

to save the mother. It can generally be diagnosed from the tubal form by its being so closly bound to the uterus, or it may bulge into the uterine cavity. In this latter case the treatment is readily outlined.

Simply dilate the cervix and deliver.

### CAUSES.

As the cause has little to do with the treatment, I will say but little about it. Changes occur in the calibre of the tube from inflammation. This inflammation may produce desquamation of the epithelium, or stenosis from adhesions. Or, from cicatricial bands around the tube, forming pouches for the lodgment of the ovum. Some authors claim that th ovum is usually impregnated in the tube. If this is true, it will not be so difficult to understand why this form of pregnancy is so frequent. For after impregnation the ovum rapidly increases in size and it is very liable to be obstructed at the isthmus of the tube.

Changes also quickly take place in the tube. The walls at first become thicker, because of increased blood supply. This continues for about two weeks. Then the walls begin to grow thin from stretching due to growth of ovum. The walls also grow weaker from the ingrowth of the chorionic villi. fimbriated extremity gradually narrows and is closed completely at the eighth week. Tubal abortion is not possible after that time, and the rupture can occur only in the tubal wall. The rupture may be hastened by external causes, such as lifting, straining, a sudden unexpected misstep or coitus. From internal causes, such as hemorrhage from or separation of the tubo-chorionic vessels. The rupture may take place through the portion covered by peritoneum into the abdominal cavity, or it may rupture through the part not covered by peritoneum, into the folds of the broad ligament. Classified as intra and extra-peritoneal rupture. Intra-peritoneal rupture is often immediately fatal. If the rupture is small, and is not near any important blood vessels, or the opening is filled up by the chorion, the hemorrhage is not fatal. The blood collects gradually in the cul-de-sac and slowly clots, and peritoneal adhesions soon roof it in. The adhesions may become organized into a new sac. This new sac may rupture and be fatal at any time, or these ruptures may recur repeatedly. The feetus usually dies at first rupture, but may go to term. New membranes may form around it or it may be left free in abdominal cavity, and the placenta still retain its hold in the tube, and thus furnish nutrition to the feetus. It is then called abdominal pregnancy but was originally tubal. Rupture into the broad ligament—extra-peritoneal—is generally fatal to the child, but not so fatal to the mother or child as the other form. Nearly all full term feetuses are extra-peritoneal. The chorion and later the placenta enlarge their hold upon the mother's tissues or organs so as to receive enough blood to maintain life in the child.

The placenta most frequently fastens itself well down in the pelvis, but may be fastened to any of the tissues or organs of the pelvis or abdomen. The omentum, intestines, liver, spleen, any or all of these may be involved in the placental implanation.

It is this possibility that makes it necessary for us to be prepared for any emergency in every operative case we meet. In the extra-peritoneal variety the folds of the broad ligament are pushed apart. Uterus forced to one side and crowded up out of the pelvis, together with the peritoneum and all the contents of the pelvis and abdomen. Secondary hemorrhage may occur into abdominal cavity in this form of pregnancy, and results fatally or not according to amount of blood lost and location of rupture in its relation to the placenta.

Tubal abortion can only occur during the first eight weeks. Tubal rupture generally occurs from the third to twelfth week. Average is eight weeks.

In early rupture and death of the fœtus, the ovum and its surrounding membranes are usually absorbed.

When the fœtus lives to be more than three or four months old it may mummify, calcify, turn to adipose or suppurate. Fœtus never goes to term in the tube. May in the abdominal cavity, but it most frequently goes to term in the broad ligament.

### DIAGNOSIS.

More depends upon early diagnosis in this than in any other condition which the obstetrician has to meet.

So I feel justified in going somewhat into detail regarding the history and symptoms of every case I see for the purpose of reaching an early diagnosis.

During the early weeks there are the usual signs of pregnancy, except there is apt to be more or less flow at time of first and second menstrural period. The patient generally concludes that she is pregnant and very often does not consult the doctor until collapsed from rupture. At this time there is a sudden, sharp pain on one side. Excruciating in character. Patient feels faint and dizzy. May lose consciousness. Vomits. Has cold, clammy sweats. Pulse rapid. Temperature below normal as a rule. More or less hemorrhage from the uterus. Due to separation of uterine decidua. Patient, and possibly doctor, concludes there has been a miscarriage. Some discharge may continue for weeks, containing shreds and clots often. If the microscope tells that there are no chorionic villi. miscarriage is ruled out, and diagnosis of ectopic gestation almost certain. Pelvic peritonitis develops rapidly as a rule. Ruptures recur occasionally.

#### RECAPITULATION.

Menstrural irregularity. Symptoms of pregnancy. Sudden sharp pain. Syncope and vomiting. Metorrhagia, and all these symptoms are preceded by a period of sterility as a rule.

Within the last five years so much has been done to clear up these cases that diagnosis before rupture is quite possible, and in the hands of experts the rule, provided they see the patient in time. This early diagnosis is so essential to the welfare of the patient that we may almost say her life depends upon it. This being true, I take the time, even at the risk of repetition, of enlarging some upon the early symptoms of tubal gestation.

First let me speak of the physical signs. Before rupture. Distended tube, with more of a boggy feel than in hydro or pyosalpinx. Uterus enlarged. Enlargement most marked in long diameter of uterus. Cervix soft. Os patulous.

Immediately after rupture. There is no distinct tumor. Sensation of fluid or indistinct doughy feel in pelvis. Especially in Douglas' pouch. Symptoms of internal hemorrhage. Rupture in broad ligament gives us hematoma. Blood clots

quickly, and is quite firm, because the broad ligament holds it firmly and the pressure is sufficient to cause firm clots and arrest the hemorrhage.

Three keynote symptoms I will repeat: I, Pain, its character, location and manner of occurrence. 2, Irregularity rather than suppression of menses, and often accompanied by uterine decidua without the chorionic villi. 3, Small lump in the tube, size of the thumb and not adherent at first. This lump soon becomes tender and fixed by adhesions. These lumps are very vascular. Often pulsating under the finger. I always make it a point to obtain as full a statement as possible regarding the pain in the patient's own words. They all speak of it as excruciating in character, coming on in paroxysms, with intervals of freedom from pain. These attacks of pain are likely to come, two or possibly three weeks after menstruation. Generally in one groin, though they may be across the abdomen. Extending down one leg, or up to the epigastrium. Being so very severe as to cause profound systemic disturbances. The terrible pain often causing more shock than the hemorrhage. In fact shock may be very profound and little hemorrhage found at time of operation.

# DIFFERENTIAL DIAGNOSIS.

It will require some care to distinguish ectopic pregnancy from the following: Before rupture physical signs are similar in this and the hydro or pyosalpinx. Before rupture in ectopic pregnancy there are the usual signs of pregnancy and these are not present in either of the other conditions. After rupture in ectopic pregnancy pulse is more frequent. Temperature subnormal (a rare combination) and the pain is very severe, but short and recurring. Loss of blood, or collapse very marked. Septic symptoms absent or slow in developing. In pyosalpinx, pulse is slow, and gradually increases in strength and rapidity. Pain lasts longer and is more steady but not so severe. No loss of blood internally or collapse present. Sepis manifested early and increases rapidly. It is sometimes difficult, from physical signs alone, to differentiate this from fibroid of ovary, or fibro-myoma. But the history will clear up all doubts. Fibroid is of slow growth. Much harder, and fibromyoma is more intimately connected with the uterus.





They may both be present, when the patient's condition is indeed serious. Ovarian cysts readily told by history and absence of pregnancy symptoms.

Hematocele is so nearly synonymous with ectopic pregnancy that I will not take time to discuss it further.

#### TREATMENT.

During the last few years, or I might perhaps better say, during the last two years, there has come such a change in the minds of the profession regarding the treatment of this condition that we are not justified in concluding that any fixed standard of procedure has yet been reached. At present and for sometime to come each physician will be more or less influenced by his personal predilections. Some will adopt the so-called expectant treatment. Others will try to kill the fœtus by electricity. While still others, those of a surgical turn, will advocate and practice surgical procedures in all cases. These will in all cases resort to laparotomy or elytrotomy according to the location of the fœtus and placenta, or according to the bias of the operator for the vaginal or abdominal route. In my opinion, elytrotomy is applicable only in cases where the fœtus is dead. Or is impacted in the pelvis and we are pretty certain before operating that the placenta is attached high up in the pelvis or in the abdomen.

Even then all we can do is to remove the fœtus, drain through the vagina and allow the placenta and membranes to come away by degrees.

It is perhaps true that electricity is not as much used as formerly, but I still feel that before the death of the fœtus, which generally occurs at the time of rupture of the sac, there may be conditions or circumstances under which electricity should be used in preference to the knife. Ectopic gestation snould always be looked upon as a grave obstetric complication. One in which the life of the mother is in constant jeopardy. The chances for the child are so very remote as to hardly be taken into account. So our whole thought should be for the mother.

If the attending physician is not a skilled operator. If he is far removed from such help and there are no urgent symptoms he is justified in using electricity for the purpose of killing

the fœtus. This is allowable in the earlier months of gestation. Not later than the fourth month. The faradic current is the only one to be thought of. Place the negative electrode in the rectum or vagina. Whichever will bring the electrode the nearest to the sac. The positive pole with a large, flat electrode on the abdomen just over the sac. Allow the current to run five or ten minutes. Let the strength be regulated by the tolerance of the patient. Continue this daily until the sac begins to grow smaller. Then you may know the fœtus is dead, and the liquor amnii is being absorbed. We must not forget the fact that the electric current sometimes ruptures the sac, but by anticipating such a contingency we will be prepared to combat the resulting collapse, and tide the patient over the crisis.

#### LAPAROTOMY.

Before rupture the operation is comparatively easy for one accustomed to abdominal work. Simply tie ovarian artery at distal and proximal end of the tube, and take out the mass. If sac is not broken in removal the abdomen is closed without drainage. After rupture into abdominal cavity prepare to open the abdomen at once. If operation is imperative, it is demanded because of hemorrhage.

Should the pulse show any sign of improvement, wait until shock is over. When the patient has rallied from the shock it is best to operate as a rule. This must be done rapidly as the patient, at best, is not in a very good condition for such a serious operation. Enter the abdomen through a good, free opening and first seize and ligate the bleeding vessels, if any can be found. If not readily found, tie the ovarian artery, and then take time to clean out the blood clots and all the products of conception. Flush the cavity and as a rule leave in drainage. To tide the patient over the shock flush the cavity thoroughly with saline solution, and after the cavity is clean leave in some of the solution. Only a few days ago this expedient brought the pulse from forty, and very feeble, up to sixty-eight, full and strong, in two minutes in a patient upon whom I was operating.

In extra-peritoneal rupture the shock is not so great. Do not operate as a rule. Keep the patient quiet and apply cold

at first, and later apply heat. Fomentations of poppy heads have served me well in four cases. Have two sacks and change as often as need be to keep them hot and to control the pain. Absorption generally takes place in due time. If it does not there may be suppuration, caused by absorption of poisons from the intestinal canal. In this case drainage through the vagina is the best method of treatment. If hemorrhages recur laparotomy will be indicated.

We have thus far had in mind the treatment during the first four months of gestation. After this period the treatment embodies some different principles and will necessitate somewhat extended notice. Remember that in nearly all these cases the fœtus is extra-peritoneal. In all cases where operation is undertaken keep outside of the peritoneal cavity if possible. After the fourth month rupture is not so liable to occur. by that time the placenta has secured such a firm hold that life can be maintained for the whole period of gestation. is easy as a rule to tell whether the child is alive. Fœtal heart sounds can generally be detected. And ballottement can generally be practiced. The fœtal movements are quite distinct after the fifth month. These, together with the rapid increase in the size of the abdomen, are sufficient to make the diagnosis clear. At this stage we are brought face to face with a serious problem. Operation should not be lightly considered, because there are great probabilities of death from hemorrhage at this stage of development. Should the symptoms call for an operation it must be performed very rapidly. Make a large opening in the abdominal wall so as to be able to locate the placenta promptly. Do not disturb this. Open the sac and extract the fœtus. Cleanse the sac. Stitch it to the abdominal wall and pack the sac cavity to control hemorrhage. Leaving the placenta to separate by degrees. Watch the placenta at each dressing, and if it can safely be done at any time, take it away in a mass. If it cannot so be removed, it must be allowed to come away by piecemeal. This is the usual mode of procedure, for the long standing abnormal conditions have produced such extensive deposits, and firm adhesions, that the products of conception cannot be removed at the time of operation. Of course remove sac and all if possible, but do

not take too many chances of fatal hemorrhage by disturbing the placenta. At the time of spurious labor the sac may be ruptured. If it is, our only hope rests in operation. Always be prepared to operate with but a moment's notice. Rupture here can be told at once and we must operate. If the sac does not rupture the fœtus will die in due time from the shock of labor. After its death the spurious labor ceases. With the death of the fœtus, we still have a serious condition to deal with, but all agree that it is best to watch the case closely, but not to operate unless urgent conditions demand it. These conditions will be peritonitis, or some form of blood poisoning.

Our reason for delay is that we expect the liquor amnii to be absorbed, and the circulation in the placenta gradually cut off. The operation can then be undertaken with reasonable assurance of success. If we find an opening in the sac and that the placenta still has more or less circulation, the operator must decide what course to pursue in the case in hand. Keeping ever in mind the immediate danger of hemorrhage on the one hand and the more remote but equally serious danger from sepsis, on the other, and choose the best plan for the case in hand.

There is a great difference of opinion as to the best course to take after the death of the fœtus, and all immediate danger of infection I as passed. The weight of authority is undoubtedly in favor of operation, and not trusting to nature to keep all the organs and tissues in harmless state. I have had no personal experience in cases of long retained products of ectopic gestation.

Prof. James C. Wood, of Cleveland, Ohio, has an excellent article in the first issue of the Homeopathic Journal of Surgery. He therein gives the history of an exceedingly interesting case where he successfully removed a lithopedian of years standing.

It is always best to remove these feetal remains by laparotomy no matter what condition they may be in, as their presence is always a menace to the health and life of the parent.

Numerous cases are on record where the products of conception have excited suppuration, resulting in long periods of ill health, or perhaps death, many months, or even years, after the death of the fœtus.

Since reading Lawson Tait's famous article some thirteen years ago I have had eleven undoubted cases of ectopic gestation all told. Before then, I presume, I had cases but did not recognize them. The following case is chosen because of its peculiar features and special interest.

Mrs. B., aged thirty-four years, was admitted to the Homeopathic Hospital of Michigan University at Ann Arbor, March 10, 1898. Her history, briefly outlined, is as follows:

She was married in February, 1897. Her health had been very poor for several years. Menses irregular, scanty, and very painful all these years. Late in November, 1897, nine months after marriage, she was taken with a severe attack of what was diagnosed at the time as gastritis. In a few days the fever subsided and she had all the usual signs of pregnancy. The stomach was also unusually irritable. This condition continued until in January, 1898, when she was suddenly taken with very severe pain in the lower abdomen, and this could only be controlled by morphine. After these pains had continued for a week or so, during which time she had often been so low that they thought her dead, she began to flow quite freely and passed a mass of blood clots and membranes. The attendants concluded that she had aborted. But it was evidently the uterine decidua of ectopic gestation.

She then rallied a little and was able to take a little food, and could, with the greatest care, be turned a little in bed. Temperature was below normal for the first day and 101° to 102° for two weeks.

These attacks recurred about every two weeks, each being less painful, but leaving her weaker until about the first of March. She then rallied a little, and on the tenth of March was taken to our hospital for the purpose of having a large ovarian tumor removed, as they said to us. She was nearly moribund when she entered the hospital, and it required the most watchful care for several days to keep her alive. When she had rallied a little I made a careful manual examination. The patient was too weak to take chloroform. I found a mass firmly imbedded in the right side of the pelvis. This was about two and a half inches thick, four and a half inches wide and twelve inches long. This was firmly fastened to the right

side and part of pelvis. This mass was very firm but not tender. After obtaining a careful history of the case and repeated examinations, I diagnosed ectopic gestation, and made all arrangements to operate as soon as patient was strong enough. She was very weak indeed. At this time weighed but sixtvfour pounds. Weighed one hundred and seven pounds when taken sick in November. She really looked more like a corpse than a living woman. This examination was made on the thirteenth of March. On the fourteenth she had another collapse. The relapses occurred about every two days for over two weeks, so that there was not enough gain in strength to justify operation. Since entering the hospital she had been taking kali iodide and china internally and poppy fomentations were applied externally. Early in April she had gained enough to make it safe to give chloroform, which was done and a thorough examination made. Very much to my surprise, I found the growth quite a good deal smaller. Of course, I felt encouraged at the outlook and decided to give nature time to absorb the mass of blood clots and membranes, holding myself in readiness to operate at any moment if conditions demanded it. Continued the iodide of potash, with an occasional dose of hydrastis for the stomach trouble. At the present writing (June 18th) the mass is all absorbed except a small lump at the fimbriated extremity of the tube. This is not tender but quite hard. Is growing smaller gradually. If it does not continue to do well I shall remove it through the abdomen. Patient is now menstruating with less pain than ever in her life, and more natural in quantity and character. Has gained twenty pounds in weight, looks, feels, and is much better in every way. An important factor in the rapid absorption of the deposit, as I consider it, was the local treatment I gave during the months of April, May and June.

This consisted mainly in the application of iodine compound to the endometrium, and the placing of vaginal wool tampon saturated with a mixture of glycerine, calendula, geranium and carbolic acid. This treatment was given every third or fourth day. Of course the uterus was well dilated and cleaned out at each treatment. The uterine walls were so soft and friable that I felt it was safer to swab out the cavity with

iodoform gauze rather than use the curette. Copious hot vaginal douches were given daily.

Let us draw a few conclusions from this case. With proper care the correct diagnosis could readily have been made out before the time of rupture and an operation could have been safely performed. At the time of the first rupture was also a good time to operate.

When she entered the hospital an operation was not to be thought of as at all safe. Our only course was to keep the patient alive with stimulants, given hypodermically until nature could come to our aid. This she did in a few days. The rupture occurred so early in gestation that all the products of the conception are absorbed, and in a few weeks, with proper care, this woman will be perfectly well.

Do not for a moment look upon this case as being my idea of the proper treatment for ectopic gestation. I have reported it because it is out of the ordinary run of cases, and yet any of you are liable to meet such cases, and my experience may be of value to you.



# LINGERING LABOR IN THE FIRST STAGE: ITS CAUSES AND TREATMENT.

BY L. L. DANFORTH, M.D., NEW YORK CITY.

Read before the American Institute of Homeopathy, June, 1898.

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Another year has passed away and we are gathered here in this obstetrical section of our national society for the purpose of increasing our knowledge, enlarging our views, and broadening our conceptions of the dignity of our high calling by personal contact with our fellows; of giving and receiving from the great store-house of personally acquired experience that which will enable us to return to our chosen fields of work in the hope that we may attain to a higher standard of success than we have ever reached before.

I believe that this is the motive which has prompted each member of this Society as he has journeyed hither, and I trust that in no wise will he be disappointed in this endeavor. I think we are to be congratulated on being able to assemble here at a time and in an age when everything relating to our profession has reached a pinnacle of absorbing interest and of the highest good to mankind; but it would be the height of folly to fold our hands and cease our efforts, for we have much yet to learn if we would keep abreast of this rapidly advancing age, an age in which the future scientific interest, practical extension and proportionate beneficence of our science and art seem to be unlimited.

We are here, fellow members, to discuss topics relating to the special department of midwifery. I hope to hold your interest for a brief period by referring to a topic which directly concerns the daily routine of professional life in promoting the comfort and welfare of our patients, and is therefore eminently worthy of your distinguished consideration. I refer to "Lingering Labor in the First Stage: Its Causes and Treatment." I shall endeavor to be as brief as possible, even dogmatic in discussing questions which to be fully studied would require infinitely more time than I have at my disposal. I can do little more than merely indicate some of the topics which naturally suggest themselves for consideration. Very likely

these will not meet with general acceptance, but they will at least form a text for debate and may possibly elicit a valuable expression of opinion from the learned physicians present, who must have had a large practical experience in actual midwifery work. I shall classify the causes of lingering labor in the first stage as follows:

- 1st. A rigid and undilated cervix.
- 2d. Slight disproportion between the head of the child and pelvic inlet whether due to actual contraction of the conjugate, or to the relatively large size of the child's head.
- 3d. Malposition and malpresentation of the presenting part.
  - 4th. Uterine inertia from inherent weakness of the womb.

In discussing the first division of the subject, viz., the rigid cervix, it may be stated almost as an axiom, that there is as a rule no real obstacle to delivery in the state of the cervix itself. This part of the uterus will dilate readily enough provided the expulsive forces be properly acting, and in dealing with this condition our first object will be to ascertain, and if possible to remove the condition which is interfering with the normal progress of the case. This can only be done by a careful examination of all the factors entering into the solution of the mechanical problem involved. I have stated that as a rule the cervix will dilate properly provided the expulsive powers be acting efficiently. In making this broad statement I am conscious of the fact that sometimes non-dilation is due to structural causes, such as malignant indurations or cicatrices from former injuries or operations; but these conditions are extremely rare. When they exist they are easily discovered and the treatment is at once obvious. In the consideration of causes I refer especially to the difficulty frequently met with arising from non-dilation caused by inertia or by irregular or cramp-like pains; also premature rupture of the membranes (or what is practically equivalent to premature rupture), scantiness of the liquor amnii with perhaps a thick tough inelastic sac; or again, and not less important, non-dilatation arising from excessive sensibility (hyperesthesia) of the dilating structures, a condition which is but the local expression of a generally hypersensitive state of the whole system. It is quite true that these conditions in themselves are not serious obstacles to the ultimate termination of the first stage of labor without the intervention of any means that our art can supply. But that they are serious in the sense that they often greatly prolong the first stage of labor and add materially to the painfulness of the dilatation no one with practical experience will deny. I cannot agree with the old dictum that protraction of the first stage is of no importance, provided the membranes are unruptured, or that the suffering which attends the first stage is of little consequence. It was formerly stated by obstetric writers that labor is not to be considered as even tedious unless more than twenty-four hours have elapsed, and furthermore that no matter how long the delay we are not justified in interfering unless we find symptoms of exhaustion resulting.

In Blundell's classical work (1842) we are told that "In lingering labors generally, unless there are symptoms of danger, the less you interfere the better, for a meddlesome midwifery is bad; and if the protraction of the delivery be the only inconvenience which the patient suffers, and there are no convulsions, no floodings, nor well-marked signs of collapse to excite alarm, it is scarcely necessary the accoucheur should interfere at all."

Such advice as this is very correct provided all the processes concerned in the physiological dilatation of the cervix are performed in a perfectly normal manner.

Such a first stage even though prolonged over a space of ten, or twelve, or fifteen hours, while fatiguing and more or less exhausting does not call for special treatment. But the question which it is desired should be brought out clearly is this: shall a first stage be allowed to drag on hour after hour when the physiological conditions concerned in the act are not being properly performed? Is the mere fact that the membranes are as yet unruptured and presumably, therefore, no danger threatening the child, a sufficient reason why the accoucheur should stand idly by with folded hands doing nothing hour after hour until symptoms of mischief have actually arisen? Is not the mere wear and tear of a labor lasting twenty-four hours or more in itself a serious thing, and is it

not merciful and wise to adopt such means as will tend to minimize the pain, shorten the duration of the first stage of labor and thus conserve the strength of the patient that she may be the better prepared for the more arduous efforts of the second stage, as well as predisposed thereby to a more rapid and comfortable convalescense?

It is important to bear in mind the fact that although pain is the usual and necessary accompaniment of labor and is in a certain sense an important physiological factor, it is in its essence pathological. Pain during labor depends mainly upon two conditions; first the susceptibility of the patient, and, second, the state of the expelling and resisting forces. If susceptibility is great and the expelling forces urgent, at the same time that the resistence is nearly equal to the expelling power, the dilatation of the cervix and the advance of the presenting part will not only be temporarily checked but excruciating pain will become an added factor of the utmost gravity.

Through reflex influences, partial or complete inhibition of the nerves which send their motor impulses to the muscular fibres of the uterus results, and uterine activity is either greatly modified or ceases altogether.

Herein lies the justification of my remarks concerning the adoption of such mechanical and medicinal means as have for their object the shortening of the first stage of labor when unduly prolonged, and the mitigation of pain when this becomes severe and exhausting.

It is a matter of common experience that homeopathic remedies accurately administered will increase weak pains, regulate spasmodic pains and otherwise so harmonize the forces of nature that labor will progress in a natural manner. But it is not my purpose to refer to this part of the subject, and so far as purely oxytoxic drugs are concerned, they will be considered by another writer at this meeting.

The class of cases to which my comments especially apply are those in which nature is embarrassed by some physical obstacle and hence ceases her efforts, partially or wholly, until the fault is rectified spontaneously or by art.

Many cases of lingering and painful labor may be relieved by the application of a few common sense rules to the management of the membranes.

Extremely painful labor is often observed when the head of the child is well engaged in the cavity of the true pelvis (as in primiparæ) when the labor begins. The head will then be found distending to the utmost the lower segment of the womb, putting all the tissues on the stretch until they are so thin and tightly drawn as to be scarcely distinguishable from the scalp of the child, the os itself being directed backward toward the hollow of the sacrum, and so high up as to be felt with difficulty. In these cases the force of the uterine contractions is directed in a line anterior to the mouth of the womb and is therefore spent in fruitless and painful efforts in still further distending the thinned and sensitive anterior uterine wall instead of the os, as would be the case under more natural conditions. The head by its size and low position also acts as a ball-valve and prevents the formation of an efficient bag of waters.

If, under these circumstances, the head be pushed up in the intervals between pains an opportunity will be afforded for the descent of the liquor-amnii and pressure on the sensitive cervix will in a great measure be removed; at the same time the finger should be placed in the os, and its position changed by drawing it forward so that the direction of the uterine driving force and the center of the os will be on the same pelvic axis. You have thus created an efficient bag of waters, rendered effectual the driving force, and by so doing have transformed abnormal into normal conditions, all of which will facilitate dilatation and lessen pain.

In some cases the uterus will fail to act properly owing to overdistension, as in time-pregnancies and polyhydramnois. The first stage may be greatly delayed in consequence of this condition alone. If, on careful examination, it be found that the cervix is dilatable, and all that is required is more efficient uterine action, rupture of the sac in the interval between pains, at a point as remote as possible from the center of the os, will prove a very efficient means of increasing uterine action and dilating the cervix.

In an occasional case the first stage is prolonged and rendered needlessly painful by a small amount of "fore waters," and a tough inelastic sac, or at least a sac which has never become thinned, because it has never been "put upon the stretch," so to speak, by the force of the uterine contractions. When this state exists great good will be accomplished by lifting up the head, allowing the waters to descend, thus creating a fuller sac, and, perhaps, at an opportune time rupturing the sac, if the cervix possesses a fair degree of dilatability. Amongst mechanical processes used in the treatment of undilated os, manual dilatation with the finger, long held a prominent place and at one time in the history of midwifery was the subject of much acrimonious discussion, having been recommended by Smellie, Burns, Gooch and other prominent obstetricians in England, and as strongly denounced by others, particularly by Denman, who calls it "an abominable practice."

Whatever may be the adverse comments of some practitioners, I am convinced that it is a sound, practical observation, and promotes dilatation to a remarkable degree, if the finger be swept around the inner circle of the os, and at the same time the os stretched to a moderate degree.

Whether this manoeuvre acts by separating adhesions which retard dilatation or by stimulating the nerve supply of the uterine muscles by irritation of those of the os, I am unable to say, though it would seem that the latter theory were the more probable. When the head is low down in the pelvis, the os soft and unrelaxed and membranes ruptured, it is good practice to push, as it were, the os over the head, since the progress of the case is thereby often expedited. It requires some judgment and practical experience as to the proper cases in which this expedient is to be used. The procedure is capable of much abuse, and should be employed only by skilful and careful hands. Pushing up the swollen anterior lip when impacted between the head and pubes, is also not only legitimate, but essential, to save injury to the os. gentle pressure of the finger is obviously much less likely to be harmful than the long continued bruising to which the uterine structures would otherwise be subjected.

Now as to the control of pain when this is a factor per se in the first stage of labor. All practical obstetricians are aware of the great and prolonged suffering which often attends the first stage, even when we do all we can by means of homeopathic remedies and local means for its relief.

How often do we observe a case in which apparently all the conditions are favorable; good uterine contraction at regular intervals; a normal sac developing surely though slowly as it performs its functions in dilating the cervix, and yet the pain which the patient suffers becomes almost intolerable and proportionately exhausting!

Again, when the bag of waters ruptures prematurely and the head of the child presses on the sensitive cervical tissues, how painful is the process and how tedious as it drags on hour after hour!

Often the os will be found high up, so as to be reached with difficulty, slightly patulous and rigid, thus presenting a condition which almost surely forebodes a slow, tedious, and painful labor. In such conditions the imperative duty of the accoucheur is to relieve pain, relax the tissues, and lessen the spasmodic uterine action, all of which are recognized causes of non-dilatation of the cervix. This may be done by the use of a remedy which is an analogue of chloroform, viz: chloral, the use of which in this connection was first suggested by W. S. Playfair, of London, in 1874, and has since been used very generally by physicians of the "old school," though very little, I believe, by homeopathic physicians. But why should it not be? Most of us at the present time employ and few decry the use of chloroform in the second stage of labor, though all admit that it possesses certain disadvantages when given over-freely, since it distinctly retards labor by lessening uterine action and thereby predisposes to uterine inertia. Choral has no such disadvantages, and while not so anesthetic as chloroform, it is distinctly hypnotic and moreover does not in any way derange the natural processes of labor; it does not affect the motor nerves nor impair the contraction of muscle, and although it does not directly suspend the functions of the sensory nerves, it relieves certain kinds of pain due to irregular or over-action of unstriped muscular fibres. Hence its utility as a remedy for the relief of the so-called "nagging pains" of the first stage of labor. Playfair says: "Since using chloral I have practically never had any trouble

from the rigid cervix which formerly used to give so much worry. Under the use of this agent the pains become longer, steadier and more efficient; the patient falls into a somnolent condition, dozing quietly between the pains, which are not lessened or annulled, as is the case when chloroform is inhaled freely; and above all the wild state of excitement which is so frequent in this class of labor is calmed and soothed, to the infinite relief of patient and practitioners." Schroeder says: "Chloral has been given in tardy and exhausting labors. After an hour's sleep, on awakening, the labor was very rapidly terminated by powerful pains. We have also observed that by the use of chloral in cases where the uterine action was very painful without being efficacious, the labor assumed an instantaneously rapid course, although the intervals between the pains had considerably increased in duration." Atkinson, of Philadelphia, says: "It would appear that even while chloral produces a calm, refreshing sleep it does not by any means entirely check the progress of labor when this act has commenced. For it is invariably found that dilatation has gone forward, and generally, so completely is this accomplished, that on the patient awakening, a few quick pains will often complete the delivery. I regard the use of this remedy as producing results similar to those of an anesthetic in surgery, and therefore similarly indicated. While it relieves to a marked degree the pains of travail, it measurably contributes to a safe and speedy convalescence." To accomplish these beneficent results it is not necessary to administer doses of any unsafe amount. Fifteen grains, repeated in twenty minutes either by mouth or rectum, is generally sufficient to produce an effect lasting over several hours. Possibly a third dose may occasionally be required, but never more.

I would call your attention next to another question, the second in our classification, viz.: Delayed first stage from slight disproportion between the head of the child and the pelvic inlet, whether due to the contraction of the conjugate, or to the relatively large size of the child's head.

The first stage of labor is often unduly prolonged by causes which are not apparent or even suspected at the beginning of labor. Among the most important of these is the one I

have just presented. By what indications are we able to recognize such disproportion and how are we to proceed when the exact nature of the difficulty is recognized? No greater problem confronts the obstetrician than the determination of this question, since upon its correct solution may depend the life of the child and perhaps of the mother as well.

Pronounced pelvic deformity of a high degree at once arrests the attention of the obstetrician and the appropriate procedure is apparent without much difficulty. But not so when slight disproportion exists, since to the casual investigation all appears normal, and it is not until the labor has dragged on its wearying course past the usual time for the first stage to be completed that any abnormal condition is even suspected. Whenever the head of the child does not engage so that the parietal protuberances are apposed to the symphysis and the promontory respectively, in other words when the head is resting on the pelvic brim, but not engaged in it, after the continuance of strong labor pains for a period of three or four hours, I would urge that no more time be wasted in expectancy, but that an effort be made at once to ascertain the cause of the delay. I have known cases where this state of things was allowed to drag on twenty-four hours and more, even until the waters had drained away, the patient herself had become utterly exhausted, and the life of the child jeopardized, if not actually lost, before any attempt was made to ascertain the nature of the difficulty. There is one indication at least whereby we may know whether the bag of waters is being influenced by the uterine contractions and that is by observing whether or not the cervix is subject to tension at the height of the "pain." Before the rupture of the membranes, the uterine contraction at its acme will cause the sac to bulge somewhat; but in spite of this the cervix often dilates slowly or not at all, and remains about the same hour after hour; thus showing that there is some impediment to proper uterine action either of the nature of over-distension, malpresentation. or retention of the head above the brim from relative dispro-But premature rupture of the membranes oftener happens than delayed rupture under these circumstances because the presenting part does not fill the os uteri and shut off the "fore waters" from the general intra-uterine pressure. In such a case after rupture of the membranes the presenting part does not come into the os uteri to dilate it, and it is therefore uninfluenced by the pressure and is only very slowly and imperfectly influenced by the uterine contraction; the cervix therefore hangs "fringe-like" below the presenting head. Having by these indications arrived at the conclusion that there is some reason why the head does not engage and the first stage of labor come to its natural termination, the next duty is to ascertain the cause of the delay. This requires a careful internal examination to determine the exact relation of the head to the pelvic inlet, and involves also some observations on pelvimetry. I cannot refrain from saying a few words on the subject of pelvimetry, which as a part of obstetrical study has received far less attention than its merits The educated obstetrician of the future will be expected to make such observations, by means of his hand, and the pelvimeter, as will enable him to determine with sufficient accuracy for all practical purposes, the dimensions of the pelvic inlet, to say whether it is the conjugate alone, or all the diameters of the brim which are diminished, and approximately the degree of the contraction as well as the relation which the contained body—the child—bears to the passage which it is by nature intended to pass through. express the hope that obstetricians will pay more attention to this subject in the future, since by so doing they will be able to decide upon the relative merits of the different operations which often come into intimate and perplexing competition with each other.

In delayed first stage when an obstacle exists to natural engagement of the head two measures are open to us—if it is decided that the natural forces are unequal to the task of delivery, viz.: forceps and version. I will define the indications for each procedure when the head is at the superior strait.

First the Forceps.—As preliminary it must be determined that the conjugate measure three (3) inches or more; that the child is alive; and the uterine contractions are present. Then the position of the head must be accurately made out; if it is lying with its long diameter transverse, the anterior fontanelle

as low down as the posterior, and, as Litzman pointed out as an induction from clinical experience, if the sagittal suture is nearer the promontory than the symphysis, and not less than three-quarters of an inch from the former, it is fair to infer that the head has so far engaged that forceps delivery will be comparatively easy.

Herman (Difficult Labor) has also emphasized the fact that when the sagittal suture is in the position described it is good evidence that the head is entering the brim with the smallest possible diameter opposed to the conjugate. If forceps be used and traction made as nearly as possible in the axis of the pelvic inlet, the probability is that the posterior parietal bone will slip rather suddenly past the promontory, and the subsequent steps in the delivery will be easy.

Indications for Version.—If, instead of finding the head in the position described, the sagittal suture is discovered nearer the pubes than the promontory, or if the pelvis is not contracted to a high degree, yet the head is so large that its greatest diameter is high above the brim, then (the cervix being fully dilated either naturally or manually) turn and bring down a foot.

It is not my intention to enter into the comparative merits of these two operations which so frequently come into competition with each other, but I cannot close this part of my subject without emphasizing a few points which seem to me essential in dealing with any case of delayed labor in the first stage when the head is presenting. The rules for performing either the high forceps operation or version may be ever so clearly defined in one's mind, but these rules will be capable of very imperfect application unless the physician has an accurate knowledge of the position of the posterior fontanelle, and its exact relation to some determinate point on the maternal pelvis. This essential preliminary information is difficult to obtain with accuracy unless the patient is placed under an anesthetic; when this is done the hand in the pelvis can ascertain the exact location of the posterior fontanelle, the position of the parietal protuberances with relation to the promontory and the symphysis and also the direction of the sagittal suture as well as its approximate distance from

the promontory. These facts should all be made out without the least shadow of a doubt, since by so doing only can one be sure of the diagnosis in all its aspects, and be able to select intelligently and accurately the appropriate operation for the case in hand.

Malposition of the Presenting Part.—The influence of various modifications of head presentations, and of other absolutely normal presentations in modifying the first stage of labor, requires no further comment than to insist upon an accurate diagnosis of the exact presentation at the earliest possible moment since successful treatment will depend upon the solution of this problem. I need but refer to the various malpositions which are sometimes observed. Among the various anomalies of position the non-descent of the head from impingement on the pelvic brim is sometimes met with. This is the result in most cases of disproportion between the head and the pelvis. When associated with delayed rupture of the membranes the first stage of labor may be greatly prolonged, but the delay is not necessarily harmful unless the patient is deprived of rest from long continuance of the pains.

The malposition is sometimes spontaneously rectified by the rupture of the sac, an increase of the uterine action and engagement of the head.

If the cervix is soft and dilatable, we may imitate nature and rupture the membranes which will correct the difficulty by letting the head down so that it will distend the cervix and thus accelerate the force and frequency of the contractions.

The first stage of labor may be prolonged by malposition of the uterus itself which conduces by misdirection of the driving force to malpresentations of various kinds and degrees, but pre-eminently to those of the face, the brow, or the sinciput.

The early recognition of the cause of the vicious presentation and its correction by changing the axis of the uterus so that it will conform to the axis of the pelvic inlet—will be followed by good results.

The presentation of the head with its occiptal portion toward the back of the mother's pelvis, the high occipito-posterior presentation is oftener a cause of prolonged and painful first stage than is ordinarily suspected. If delay really becomes a serious factor, in consequence of prolonged pain, the hand should be inserted into the cavity of the pelvis, and the fontanelles accurately located.

If the case prove to be an occipito-posterior presentation and the cervix dilated or dilatable, it is good practice to rupture the sac if this has not already taken place, and at the same time make an attempt to rotate the occiput to the front. This may be accomplished by the use of the external hand which is used to rotate the anterior shoulder to the left and backward. while the hand inside is employed in the endeavor to rotate the occiput toward the right and to the front. The correction of transverse presentations into the more favorable and absolutely essential head or breach presentation needs only to be mentioned to be appreciated. Likewise the fact that breach presentations predispose to a slow first stage, and require no treatment, except that which conduces to rest and sleep when the dilating stage is tediously prolonged. subject of malposition and malpresentation is very closely associated with the last division of my subject, viz.: uterine inertia.

Given the case of an ordinary, average, normal woman, one fairly well built and her organism in normal condition, if inertia is present, whether primary or secondary, in a great majority of such cases it will be found on examination that the lack of action on the part of the womb is due to malposition or malpresentation of the fœtal body to the maternal pelvis. Nature's forces are so well adjusted to the task which she has set herself to fulfill that she revolts and finally absolutely refuses to make any further attempts to force the presenting part into the pelvis at an angle and under circumstances where it is mechanically impossible and a violation of the laws of physics.

Enough has been said on this phase of our subject. I would like to ask your indulgence for a few moments longer to say a few words upon primary inertia from inherent weakness of the womb, its cause and a possible danger attending this condition. I refer to fatty infiltration of the muscular tissues of the uterus. Bossi, of Novara, Italy, has recently published

(Annali di Obstet. E. Gin., December, 1896.) the results of his researches in uteri for fatty degeneration during gravidity. Three cases were studied.

The first was a primipara in the eighth month of gestation with a fibromyoma of the anterior wall of the uterus which owing to its size and location caused such distressing symptoms that a cæsarean section was performed with favorable results to the mother and child, the uterus being entirely removed. Some portions were taken from various portions of the posterior wall of the uterus which showed no trace of tibro-myoma.

The second was a woman at term whose severe hemorrhage from rupture of the uterus required immediate removal of the uterus by vagina.

The third was that of a uterus removed by cæsarean section during the last month of gestation for osteomalacia of the pelvis.

The historical results of examination of small subdivided pieces made it once clear that in all three uteri the fasciæ of the smooth muscular fibers had undergone fatty degeneration, adipose fragments in the muscular fibro-cells were prominent on account of their intensely black coloration. Careful study showed all the phases of the process from the initial stage to complete destruction of the muscular fibers. In the conclusion of his paper, based on his examination, Bossi asks the following question: "Could not this process of fatty infiltration, if far advanced and diffused, account for many cases of uterine inertia?"

In answer to the theoretical question I would state that clinical experience in my own practice and reports of cases from reliable sources, tends to an affirmative answer to the query. I believe that fatty infiltration of the muscular fibers of the gravid uterus does tend to primary inertia. I have seen several cases when I had reason to believe there was a fatty condition of the uterus and in every instance there was inertia with a prolonged first stage. These patients were abnormally fat, the pelvis lined with fat, they were easily exhausted and every one required operative interference in order to deliver.

In current literature during the past year I have seen reports

of cases which were characterized by uterine inertia, which were not only troublesome on account of this complication, but which terminated in rupture of the uterus, every one occurring without the classical symptoms of rupture; there was no tumultuous pain, no sudden cessation of labor, recession of the presenting part, or collapse.

In cases presenting such conditions as I have described, flabbiness, excessive deposit of fat, uterine inertia, whether primary or secondary, and prolonged labor, it would be difficult to decide what to do. Whether to leave the case to nature or deliver?

I shall not attempt to settle the question as to the proper course to pursue, and will close with the thought that in all cases where the inertia is primary in flabby fat subjects prolonged labor should be guarded against, and the liability to uterine rupture borne in mind.



#### RACHITIS.

#### BY W. A. HUMPHREY, M.D.

Read before the American Institute of Homeopathy, June, 1898.

Rachitis is a disease of infancy and early childlife dependent upon mal-nutrition and mal-assimilation, the results of which are manifested in the bones and bone-producing tissues, supplemented by certain phenomena in the vegetative, nervous and muscular systems.

#### CAUSATION.

The causes contributing to the development of rachitis are numerous. Children born of unhealthy parentage, upon whose constitutions are implanted the tubercular or syphilitic taint; whose nutrition is impaired from disease or from overwork and care, or who are underfed, are productive of unhealthy progeny, in whom disease finds ready soil for its development. Mothers who nurse their children through the second summer, or whose nurse is in any way impoverished from ill-health or defective nutrition or assimilation, or bad hygienic surroundings, are not proper individuals to assume the responsibility of maternity. The nutrition furnished to the child and its proper assimilation by it is, perhaps, the most important consideration in the production of this malady, yet the lack of proper food is not alone sufficient causation for its production, since children of all classes of parentage, whether rich or poor, and even when well fed, are by no means immune. It is true that babies nursed at the breast during the first twelve months are less often attacked than those brought up by hand, and when they are attacked the type of disease is much less severe. Overfeeding with the best-selected diet, to say nothing of unwholesome food, such as starch, potatoes, pork and raw fruits, relatively to the age of the child, tend to irritative dyspepsia and indirectly to defective and irregular bone development. The fact that many properly fed and properly clad children of healthy parents develop rickets, while many improperly fed and improperly clad and of unhealthy parentage do not develop it, is still a causative factor beyond these which must be made operative to render them active in the development of the disease. Lack of fresh air, sunlight and exercise, and the crowding together in unwholesome quarters in tenement districts of large cities, with persistent lack of animal fat and the proper proportion of saline ingredients in the food, adding to these the exposure to variations in temperature consequent upon such surroundings, make the development of rachitis easy.

#### ANATOMICAL CHANGES.

Rickets usually shows itself during the first two years of life, commencing often in utero. "The most characteristic change is the increased formation of vessels in bone, which is apparent even in slight attacks" (Keating). The cartilaginous canals are widened, the vessels within the canal also enlarge and eventually deposit bone-making material in the cartilage, which is deposited in an irregular manner, contrary to the regular straight lines of normal calcification in cartilage. Kassowitz says: "Much of the organic part of the bone has been laid down without the lime. The increased vascularization results in the deposit of loose, spongy tissue in the vicinity of the vessels which is deficient in lime and which continues until the end of the developmental stage. When involution begins, the vessels diminish in size, and around them is deposited new bone. The spongy tissue is hardened by a condensing osteitis." The poverty of lime found in rickets bone is not conclusive evidence of its causative influence in producing the disease, since it is impossible to reduce the supply in the food to the proportion found in the deposits of extreme cases of rickets, and since its administration alone as a therapeutic agent fails to prove curative. The red corpuscles are always below normal, as well as the hemoglobin. leucocytes are at variance with the normal. The specific gravity of the blood is below normal.

Thomas Barlow, reviewing the facts disclosed by a study of the morbid anatomy and etiology, concludes "that proliferation of cartilage with the associated increased vascularization must be regarded as pathonomis of rickets, softening of bone being a more variable and less distinctive feature; that histologically it is impossible to distinguish such a condition from that met with in the early stages of an ordinary inflammation; that we have to deal with an irritative overgrowth of ostogenetic tissue, and that this, and not deprivation of lime, is the primary factor in the disease. Whatever the irritant causing the overgrowth, it is quite certain that it is easily developed in early life. For if one fact stands out more prominently than another in the pathology of rickets it is this: that almost any injurious influence brought to bear on a child during the period of most active growth tends to produce it: a chill to the surface, inhalation of noxious gases, assimilation of ill-digested fluids, etc., may develop an irritant in the blood which acts on the tender walls of the young vessels in the growing parts of the bone."

#### SYMPTOMS.

Among the early manifestations are the beads, or "rickety rosary," at the juncture of the ribs with the cartilage. These may be the only distinctive symptoms of the disease, and yet they are of such importance as to warrant a diagnosis. A child with a previously healthy record who becomes irritable, develops a diarrhea accompanied by convulsions should place the attendant upon guard, and a careful search should be made for beads upon the ribs. The larger number of these cases end in rickets. The percentage of children subject to convulsions who develop rickets is very large, especially those who have laryngismus stridulus, which indeed is so often based upon a rachitic origin that it always is well to regard every case of it with suspicion as to its causation. The aspect of the head is altered. The anterior-posterior diameter is elongated, the outline is polygonal in contrast with the circular outline of the hydrocephalic. In others lack of symmetry prevails. bones are thin, often crackling like paper under the accoucheur's hand at birth. Generally speaking, the child is emaciated, yet he opposite condition is occasionally observed and we have fat rickets, which is easily overlooked in its earlier stages unless we search closely for the beads; their presence together with larvngeal spasms at night warrant the diagnosis. As the disease progresses and the strength wanes the ribs and spine project packward in a rounded manner in contrast to the angular projection in kyphosis from caries. Lateral curvature often finds its cause in rickets. The general weakness of the body, allowing it to incline in any direction which may have an irritation, such as pleurisy, as a starting point.

The aspect of the limbs is most markedly altered at the wrists, the radius and ulna being larger than normal at the juncture area of the epiphysis, which also becomes enlarged. The changes in the other long bones are similar, depending largely upon the severity of the attack. If it be severe and occur early, before the child walks, the bones of the arms will be bent, owing to the weight of the body being supported upon the palms of the hands as the child sits. The same is true of the lower limbs, when the child walks, being greatest in the direction of the superimposed weight. A tenderness of the limbs is a prominent symptom later on, which is, no doubt, a bone tenderness, though it may be shared by the poorly nourished muscles. Fever is absent in some and present in others, especially when there are present catarrhal conditions, which often complicate the disease, manifested in bronchial or intestinal irritation.

Rickets is by no means a rare disease. The general practitioner in smaller towns sees an occasional case only, while in larger centers of population it is classed as one of the frequent diseases. Some hospital records show the percentage to be as high as thirty. Rickets of itself is rarely fatal, but fatalities are frequent from complications. Where recovery occurs only minor deformities disappear, while grave ones persist and stamp the victim as having been rachitic the rest of his life time.



### DIAGNOSIS OF TUBERCULOSIS IN CHILDREN.

FRITZ C. ASKENSTEDT, M.D.

Since, in disease, there is a certain uniformity in the appearance and course of its symptoms which enables us to recognize specific causes and pathological changes often amenable to rational methods of treatment, medical diagnosis becomes an essential element for the intelligent treatment of the sick. With the evidence fast accumulating that during its early manifestations tuberculosis is not the incurable malady it was formerly considered to be, in no affection, perhaps, is an early diagnosis of greater importance than in the primary stages of this disease.

It has long been an observed fact that where confined to parts permitting removal, tuberculosis can often be wholly eradicated by surgical measures, while experience and postmortem examinations of patients dead with other diseases amply demonstrate the curability of extensive tubucular lesions of internal organs as well. Dr. Ditweiler, of Falkenstein, Germany, reported, some years ago, the unprecedented success of curing 36 per cent of all patients admitted with pulmonary tuberculosis, in all stages of the disease, to his institution, where hygienic measures, combined with a favorable climate, were the only means employed. Cures of cases of tubercular meningitis, confirmed by post-mortem examinations after death from other causes, have been authentically reported by such men as Riliet and Lebert, and the list would, no doubt, be considerably extended could a positive diagnosis be readily made during life. Recovery of a case of tubercular spinal meningitis was reported in 1895, in the Am. Jour. Med. Science, by Dr. Freyhan, who confirmed his diagnosis by an exploratory puncture of the spine, demonstrating the presence

Before presenting a synopsis of differential diagnosis of tuberculosis in children, let us determine what peculiar element characterizes it as a specific disease. Until bacteriology revealed the presence of the bacillus tuberculosis in the miliary

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tubercles the exact relation tuberculosis bore to allied diseases was not closely defined. In histological structure the tissue affected does not present sufficiently uniform changes to identify the disease, for the presence of tubercles with the typical arrangement of giant cells, epitheloid cells and leucocytes may be found in diseases of distinctly different clinical manifestations, such as syphilis, actinomycosis and pneumonia. while on the other hand Langhan's giant cells are frequently absent in the nodules of tuberculosis, especially in the acute Recognizing its infectious nature, modern pathologists define tuberculosis as a specific disease, due to the proliferation of the bacilli tuberculosis, associated with conglomerates of cells, mono- or multi-nucleated, which cells show a disposition to undergo caseous degeneration. Thus the demonstration of the bacilli tuberculosis in the tissues becomes a positive diagnostic evidence, and when, as in the pulmonary form, this can usually be accomplished with a few simple staining processes and a microscope, the diagnosis of the disease is, as a rule, readily determined. But, while pulmonary phthisis is the most frequently occurring form in adults, in children we meet with tuberculosis in a diversity of localities. which not only produces confusing variations of symptoms, but, at times, as in cerebral meningitis, renders microscopic analysis wholly inoperative. Hence, the most careful consideration based on symptomatology alone may sometimes fail to yield a positive diagnosis, but the difficulties which here confront us, should, rather than discourage, stimulate to a closer observation and study of all signs available, not only in a direct method of diagnosis, but in that by exclusion as well. As a final criterion in the affection of the glands, bones and skin, where microscopical examinations seldom are decisive, animal inoculations may be resorted to, but these require from four to ten weeks for development.

Desiring to avoid a tedious text-book essay, I shall endeavor, at the risk of adding nothing new to your fund of knowledge, to present a few salient points, which, if stored in memory's accessible recesses, may by differentation afford a clue to correct diagnosis.

Scrofula and tuberculosis have long been regarded as inti-

mately related diseases, but the former is now only used as a clinical term. The excessive growth of all lymphatic tissues predisposes childhood when tainted with vicious hereditary influences affecting chiefly the lymphatic system, as syphilis and tuberculosis, or when exposed to unfavorable physical surroundings, to inflammatory disorders of lymphatic glands and mucous membranes; and to this predisposition the term scrofula has more recently been restricted. Modern pathology refuses to recognize any peculiar histological structure as distinctly strumous, since it differs in no respect from that common to chronic tuberculosis. Moreover, since almost all socalled scrofulous glands are now believed to be secondary to some abrasion or inflammation of the skin or mucous membranes, and, showing a great tendency to caseate—the caseous material uniformly producing tubercular inflammations, with the bacilli, in animals experimentally inoculated—scrofula connot, in the present light of pathology, be regarded as an independent disease.

The diagnosis of tubercular glands is done largely by exclusion. The enlargement shows a slow progressive course, with none or mild symptoms of inflammation. Of all lymphatic glands the submaxillary show the greatest tendency to involvement.

Glands showing much tenderness, redness and heat point to some eruption or abrasion within their areas of absorption.

In syphilis the enlarged glands are usually found in large numbers, and have a smoother and more even surface than in tuberculosis.

Lukemia has also a number of moderately enlarged smooth glands. The proportion between anemia and emaciation is greater than in tuberculosis, epitaxis is frequent, and the spleen is usually enlarged. Microscopical examinations of the blood shows an increase in the mono-nucleated white corpuscles, with a reduction in the number of the red cells.

In Hodgkin's disease the glands are at first movable and not tender to touch, but later become confluent masses. The glands may vary in size from month to month. There is an intense anemia from destruction of red cells, palpitation, dropsy and hemorrhages not to be accounted for by a local tubercular lesion. The glands most frequently affected are the anterior cervical, but any lymphatic tissue may be primarily involved.

Pulmonary tuberculosis in children is much more difficult of recognition than in the adult because of the less favorable conditions for physical diagnosis, the less liability to involvement of the apices of the lungs, and the normally less stable relation between pulse, temperature and respiration. The family history, the previous health of the patient, the duration and general aspect of the disease must chiefly be considered in differentiating between tuberculosis, bronchitis and pneumonia. A protracted course, with evening rise of temperature, a progressive emaciation, anemia and cachexia, when associated with patches of increased resonance of the lungs, especially of the upper lobes, should lead us to suspect tubercular infection. Crepitant rales are not often elicited in young children, as they are usually marked by coarser rales.

Cough, with mucous rales, absence of consolidation, mild constitutional symptoms varying in intensity with the local obstruction, are pathognomonic of chronic bronchitis.

Chronic broncho-pneumonia resembles pulmonary tuberculosis in presenting small areas of consolidation, but while in the former the posterior borders and lower lobes of both lungs are usually affected, in the latter, the consolidations frequently involve the upper lobes.

Lobar pneumonia may, from the lack of palpable chest symptoms in the beginning of the attack, the fever, the delirium and coma suggest tubercular meningitis. It differs, however, in the rapid onset, the violence of the fever and the gradually developing physical signs of lobar hepatization.

A lingering malarial fever, of a remittent or intermittent type, with bronchitis, emaciation and anemia, sometimes simulates miliary tuberculosis so closely that a diagnosis can only be inferred from the temperature curve—the exascerbations of material fever usually occurring during the day, while the highest daily temperature of tuberculosis almost always in the evening. In this, as well as in the preceding disorders, the diagnosis may still remain in doubt, but if the cough is loose, and sputum can be obtained either by expectoration or, in

young children, by irritating the pharynx during a coughing spell, the microscope can usually settle the difficulty.

In tubercular meningitis we must, for obvious reasons, in most cases depend upon general symptomatology for its diagnosis. The indications are: Family history, a gradual onset manifested by irascibility and moroseness of temperament, headache, a tottering gait, a subnormal or only slightly elevated temperature until paralysis sets in, a retarded and irregular pulse, irregular respiration, sudden propulsive attacks of vomiting, constipation, retracted abdomen, diminished urinary secretion, stupor, coma, convulsions and paralysis.

Simple meningitis and rheumatic meningitis have a more sudden attack and a higher fever than the tubercular form.

Cerebro-spinal meningitis differs in its shorter prodromal stage, a higher temperature, comparatively less stupor, hemorrhages and exanthem.

Typhoid fever has frequently been mistaken for tubercular meningitis. The points of difference are: Onset more rapid, the cerebral symptoms are attended with more fever, the bowels are usually loose and the abdomen distended.

Hydrocephaloid may present many symptoms of meningitis. It is usually preceded by gastro-enteritis; the fontanel when open—tense and bulging in meningitis—is depressed; and a temporary improvement can usually be observed in the patient's condition after the administeration of a stimulant.

Uremic coma may be recognized by analysis of urine. The paralysis of tubercular meningitis is usually local; of uremia, general. Pupils are immovable in meningitis, but, if dilated, respond partially to light in uremic coma.

Intestinal tuberculosis is apt, especially when it is the primary lesion, to be confounded with entero-colitis. The tubercular affection ordinarily presents a progressive anemia and wasting notwithstanding an improvement in the stools, more marked cerebral disturbance, a higher temperature, frequently enlargement of the spleen and lymphatic glands, ocalized paralyses, and usually cough and patches of consolitation of the lungs. Careful microscopical examination will requently detect bacilli tuberculosis in the stools.

In chronic entero-colitis, on the other hand, we find the

constitutional symptoms in proportion to the intestinal lesion as manifested by the stools, fever only when arising from complications, depression of fontanel, less mental symptoms, no paralysis, and rarely enlargement of the spleen.

Tuberculosis of the bones or joints is often due to an infection from a primary focus. Since all chronic suppurative processes of the bones in children—so-called scrofulous inflammations—have been shown to contain the bacilli tuberculosis, the diagnostic symptoms are identical with those of chronic abscess.

On the skin, tubercular inflammation results in the formation of tubercles and papules, which by discharging upon the surface form soft, granulating ulcers leaving cicatrices on healing or showing no tendency to heal.

Lupus, the most frequently occurring form in childhood, is characterized by its slow, tedious course, the formation of soft yellowish-brown nodules, which slowly become converted into ulcers, finally cicatrizing more or less completely.

Syphilitic ulcerations differ by their more rapid course, the harder and more sharply cut edges, a greater tendency to extend to, and involve, the deeper structures, and by their simultaneous appearance on various parts of the body.

Eczema is differentiated by its greater hardness, absence of ulceration and cicatrization, and spreading by direct continuity of surface.

Finally, it must be remembered that tubercular processes are apt to become engrafted by infection upon any part or organ whose vital resistance is weakened by disease or unfavorable surroundings, and thus insiduously develop under the mask of a less formidable malady.



## Book Reviews.

Conservative Gynecology and Electro-Therapeutics. A Practical Treatise on the Diseases of Women and Their Treatment by Electricity. Third Edition, revised, rewritten, and greatly enlarged. By G. Betton Massey, M.D., Physician to the Gynecic Department of Howard Hospital, Philadelphia; Late Electro-Therapeutist to the Infirmary for Nervous Diseases, Philadelphia. Illustrated with 12 full-page original chromo-lithographic plates in 12 colors, numerous full-page original half-tone plates of photographs taken from nature, and many other engravings in the text. Royal octavo. 400 pp. Extra cloth, beveled edges, \$3.50 net. The F. A. Davis Co., Publishers, 1914-16 Cherry street, Philadelphia.

This, although a new edition of the author's work, Electricity in the Diseases of Women, has been so thoroughly rewritten and extended to include the latest advances in this subject as to become a new book, and a very thorough exposition of the application of electricity in gynecology. The title conservative justly applies to the work, as the author is not carried away with the fad of regarding gynecological treatment as essentially surgical. Nearly all the modern treatise on gynecology have been written, the author says, from a purely surgical standpoint, leading often to a perspective view of these affections that unduly exaggerated the mechanical side of pelvic pathology. Opportunity is thus afforded for the rescue from oblivion of certain neglected facts as to the origin and nature of inflammatory diseases of the uterus and adnexia, and for the fuller consideration of the neural disorders most frequently found among women, while special attention is accorded to fibroid tumors and their treatment by Apostoli method and the author's method for the treatment of cancer. The book is a thoroughly practical one, clearly written, the methods of applying the current, of diagnosis, of examination, and of the various currents and their therapeutic value being clearly set forth. The illustrations are excellent, being in the case of the colored plates from life and fully illustrates the subject. It is a work of exceptional value for the general practitioner.

Diseases of the Skin. Their Constitutional Nature and Cure. By J. Compton Burnett, M.D. Third edition, revised and enlarged. 264 pp. Cloth, \$1. Philadelphia: Boericke & Tafel; 1898.

This, the third, edition of Dr. Burnett's interesting and instructive monograph upon diseases of the skin, has been considerably enlarged by the addition of Part III., treating of the "cure of alopecia areata by constitutional remedies without any local application whatever." This is, in fact, the keynote of the book—the cure of skin diseases by constitutional treatment. As the author graphically says of the skin: "That being biologically within the organism, being fed from within, having its life from within, having its health from within and having its disease from within, it must be also treated medicinally from within, a statement with which all homeopathists will agree. The book is written in Dr. Burnett's inimitable style, with numerous illustrative cases which exemplify not only the author's theory of the cause of the diseased condition but his method of treatment as well. It is a book which can be read and reread with profit.



#### Cypripedium in Wakefulness of Children.

Children awaken from their naps before they should, awaken completely, wide awake, without apparent cause.

#### Sepia in Constipation.

For constipation after childbirth sepia is the remedy.

#### Ferrum phos. in Summer Diarrhea of Children.

In the summer diarrheas of children one finds it indicated where the patient vomits continuously, with waterv and bloody stools, and the child decidedly emaciates within twenty-four

hours. He then lies in stupor, with a red face, half-opened eyes and dilated pupils; the pulse is full and easily compressible, and it throws its head continually from one side to the other, with sudden starting during sleep.

#### Calc. carb. in Leucorrhea.

Calcarea carb. contains in its pathogenesis a milky discharge producing heat and itching of the vulva. Menses early and profuse, with aggravation of leucorrhea before the period. Mentally ill-humored; cries easily and fears she will lose her reason. The sixth trituration three times daily.

#### Plumbum in Dysmenorrhea.

The menstruation stops at the beginning of the colic.

#### Silicea in Rachitis.

Open fontanelles; head too large and rest of body emaciated; pale face; abdomen swollen and hot; ankles weak; profuse head-sweat and body dry; likes wrapping up warmly; offensive diarrhea; stools contain undigested food; swelling and suppuration of glands and bones; ulceration and necrosis; cellular inflammation.

#### Borax in Infantile Diarrhea.

Easily started, apthæ upon the tongue or inside the mouth. Child pale and hot; undigested and offensive stools. Dr. Bell makes a suggestion which we think should be remembered, that belladonna is frequently given where borax should have been.

#### Calcarea phos. in Backache.

Backaches and headaches of school girls, especially during the catamenia. With this remedy there is mental anxiety with all the troubles. Has cured a number of cases of backache in young school girls who were disappointed in their little love affairs, all their mental disappointment seeming to go to their backs.

#### Lachesis in Ovarian Pain.

Pain in left ovary, darting upward; pain and sensitiveness to weight of clothes, pain extends from right to left, boring or burning pains relieved by discharge of blood from the vagina. Intolerance of slightest touch. Physical and mental weakness. Leucorrhea, acrid, slimy green or thick yellow. Lach. is es-

pecially useful during climacteric period and for affections of weak, melancholy women or for young girls who are chlorotic with sickly complexions.

#### Lillium tig. in Leucorrhea.

Thin, acrid, excoriating, leaving a brown stain, with intermittent labor-like pains in sacral region, worse afternoon and evening.

#### Merc. in Mammary Abscess.

Especially if transient chills or throbbing indicate the probable formation of matter; also in cases where suppuration takes place in different parts of the breast.

#### Ignatia in Chorea.

When the disease is developed as a result of moral causes, spasms are worse after eating.

#### Ergot in Uterine Hemorrhage.

Hemorrhage after accouchement or abortion, rarely useful in metrorrhagia or menorrhagia—it should be employed in physiological because the hemorrhage is produced in these cases because the arteries remain open—the ergot closes them. It is sometimes useful in metrorrhagia of the menopause; flow black and of bad odor; aggravation by the least movement; skin cold; menace of collapse.

#### Rhus tox. in Scarlatina.

The rash is rough, sometimes dark colored and itches violently. There is drowsiness with muttering delirium. Tongue at first coated white with triangular red tip, then red and smooth; in worse cases dry, red and cracked. Pain in limbs and joints, causing patient to constantly change position. Ichorus yellow, thick discharge from nose.

#### Coccus cacti in Whooping Cough.

This remedy has paroxysms of cough with vomiting of clear, ropy mucus, extending in thick, long strings to the floor. This is sometimes seen in children who cough and cough with this tenacious mucus stringing from mouth and nose, waving to and fro until it finally gives way. The paroxysms come on in the morning, and accompanying them there is often vomiting of a clear, ropy mucus. Eructations of wind following cough are an indication for Ambra grisea. Coccus

is a useful remedy for the protracted bronchial catarrhs remaining after whooping cough. The excessive secretion of mucus under coccus is marked, and causes the child to strangle.

#### Podophyllum in Infantile Diarrhea.

Green, sour, watery stool, or yellow mixed with mucus and very offensive—preceded by griping colic. Stools of podo. and puls. are both changeable. May be undigested or clay colored —prolapsus ani. Great exhaustion.

#### Helonias in Uterine Disease.

Atonic condition of female organs, prolapsus with general malnutrition and mental depression; sensation of soreness and sensitiveness of the uterus; the patient "is conscious that she has a womb." Offensive leucorrhea with erosion of the cervix, which occasionally causes hemorrhage. With local uterine symptoms of displacement or of chronic inflammation, etc., there is generally pain in the lumbar region, dull aching, sometimes weight on the chest, pressure on the head. Pruritus of vulva and vagina, which are hot and swollen and exfoliate; aphthous patches. Induration of uterus.

#### Graphites in Dysmenorrhea.

Intolerable itching before menstruation and a gushing leucorrhea day or night.

#### Graphites in Climacteric.

What pulsatilla is to puberty, graphites is to the climacteric.

#### Murex in Leucorrhea.

The cervix is sore and ulcerated and there is a discharge of greenish blood-streaked leucorrhea.

#### Lachesis in Neurasthenia at the Menopause.

Lachesis in its proving has a poisonous action simulating the venom of the viper; as a clinical remedy, its symptoms are those of the adynamic forms of disease; pathologically, it develops asthenic inflammations, malignant degenerations, and a general tissue depreciation which is slow in development and still slower in the tendency to recovery. Primarily we observe its action upon the pneumogastric, and, secondarily, in the blood inoculation which permits fibrine decomposition. Through the pneumogastric it permits a loss of vasomotor in-

hibition, and hence the undue afflux of blood at different centers. Thus we see the heart depression, and the gastric and alimentary functional crisis and the uterine disorders, particularly at the time of the menopause. As it shuts off the vagus inhibition it permits successive dilation of the vaso-dilators, until by exhaustion they cannot act in consonance with the vaso-constrictors. Then occur the pronounced changes in the active functions, like menstruation.

Physiologically "the change of life" simulates the vital depression observed in the proving of lachesis. The nervous energy necessary for regular menstruation naturally becomes exhausted as a woman approaches the middle of her life; the cerebro-spinal system loses its elasticity, and pneumogastric inhibition is weakened. It is then that we notice the peculiar nervous phenomena which are incident to the time when all the energies are waning, and the system is trying to adjust itself to a new order of existence. Therefore lachesis, with its similar symptoms, is often indicated at the climacteric.

#### Trillium at the Menopause.

Trillium has a most profuse hemorrhage at the climacteric period. The flow may be bright red or dark or clotted and induced by the slightest over-exertion. Syncope, vertigo, dimness of vision, palpitation, severe pain in the back, and persistant recurrence of the flow every fourteen days. The face of the trillium patient is generally sallow, and she may even present the yellow saddle across the nose, so characteristic of sepia.

# Pądialrigs.

#### The Contagion of Whooping Cough.

Dr. Weill (Lyon Med.) on various occasions permitted nearly one hundred young children, who had not previously suffered from whooping cough, to be associated in the same ward for twenty days or more with children suffering from the disease during the stage of whooping. In only one case

was the disease contracted, and in this instance the patient from whom the infection was derived was in the very earliest period of the whooping stage. In three small epidemics Weill was able to satisfy himself that infection was contracted from children who had not yet begun to whoop. He concludes that infection ceases very soon after the characteristic whoops commence, and that therefore in a family it is not the patient who is already whooping, but his brothers and sisters who have not previously had whooping cough, that ought to be isolated.

## Cynecological Phylings.

#### Spincteric Hysterotomy.

Dr. Defontaine (Archiv. Prov. de Chir.) describes an operation for free division of the uterine cervix intended not merely as a preliminary measure in removal of an intrauterine tumor, or to facilitate exploration of the uterine cavity, but for the purpose of abolishing the functions of the sphincter, and, consequently, of modifying the physiological and patholical conditions of the uterus. Division of the sphincter, it is held, is more effectual than amputation of the cervix in causing involution of the uterus, and, consequently, of ameliorating certain forms of metritis and of uterine deviation. Sphincteric hysterotomy, the author states, is indicated in cases in which it is necessary (a) to assure evacuation of the contents of the uterine cavity; (b) to facilitate involution of the uterus; and (c) to prevent the upward extension of any infective process toward the oviducts. It is regarded as a measure of radical treatment in cases of metritis and of affections of the uterus complicated by septic inflammation, particularly uterine flexions and dysmenorrhea of uterine origin, and also, advanced retraction of the cervix. It acts by allowing complete evacuation of the uterine cavity, and by facilitating involution of the diseased organ. The operation is rendered a harmless one, if performed under proper antiseptic methods and Hydrozone is the agent recommended, and has had good results after the failure of dilatation of the sphincter and curetting. It should be practiced only in cases in which the expectation of conception no longer exists, or when the gravity of the affection leads to a disregard of inconvenient consequences in this respect. It is stated, however, that an autoplastic operation may in certain cases re-establish the uterine sphincter, and favor the possibility of pregnancy

#### Hydatiform Mole.

Dr. Murry makes the following deductions:

1. That women near the menopause who are irregular in menses should always be examined to determine the cause.

2. That the possibility of hydatiform mole being a cause of metrorrhagia and serious discharge should always be borne in mind.

3. That fibroids of the uterus may be present, yet the cause of flowing may be hydatiform mole.

4. That hydat form mole may be present without obvious

signs of pregnancy.

5. That the proper treatment of the condition is dilation of the uterus, removing the mass and packing the uterus, to be followed by ergot to keep the uterus contracted, all operations to be done aseptically, and with all means of controlling hemorrhage at hand.

6. That after the uterus is emptied the danger is not over, as the villi, which is cystic, may have perforated the uterus is first washed out by prolonged irrigation with a

the peritoneum.

#### Adenoma and Polypii of the Uterus.

These common diseases are now looked upon with more suspicion than formerly, particularly when they appear after the climacteric and recur after extirpation. Clinical experience has shown them to be often only preliminary to cancer, and a radical operation is necessary to avoid the danger. In younger women the former methods of treatment are employed, but the cases are watched carefully for any signs of trouble.

#### Management of Solid Tumors of Ovaries during Pregnancy.

Dr. Swan (Johns Hopkins Hosp. Bull.) arrives at the following deductions:

I. Solid neoplasms of the ovary, complicating pregnancy,

are exceedingly rare.

2. The diagnosis of this rare combination of a physiological and pathological process may be very difficult. The physical examination with the signs of pregnancy, and those which belong more particularly to solid ovarian growths, will generally enable us to make at least a probable diagnosis and one sufficient to warrant an explanatory section.

3. The prognosis in cases of solid growths of the ovary

complicating pregnancy is much worse, both for the mother and child, than in those of cystic neoplasms of these organs. This is to be explained by the fact that the former are usually smaller, and remain in the true pelvis and obstruct the parturient canal; while the latter, owing to their bulk and consistence, rise above the pelvis, and the dystocia, if produced at all, is of a less serious nature. Abdominal section and extirpation of solid tumors during the early months of pregnancy produce equally good results, so far as the life of the fœtus is concerned, as in the case of cysts; the ultimate result in the case of the mother depending, of course, on the malignant or benign nature of the growth.

- 4. The general rule should be to operate on all cases between the second and fourth months of gravidity. It would be hard to find a stronger argument in favor of the elective operation for extirpation of these ovarian neoplasms than is furnished by a comparison of the statistics of the best authorities.
- 5. The compulsory operation during the latter half of gestation, during labor, or the puerperium will rarely be required.

#### Puerperal Tetanus.

In the literature of puerperal tetanus the presence of Nicolaier's bacillus has been reported but three times, by Chantemesse, by Heise, and by Stern. Dr. Rubeska has observed six cases of this disease. In all of the cases there was operative interference with the labor, and infection probably resulted through wounds made at the time of the operation. Chill, fever, and fetid lochia have all been present. The symptoms usually came on in from six to nineteen days after the delivery, and the results were uniformly fatal in from two to three days.

The author has collected together all of the reported cases, twenty-one in number, and shows that in one case only did recovery take place.

#### Calcareous Degeneration in the Uterus.

Dr. Cohen (Med. World) reports a rare case of the foregoing, the patient being fifty-seven years of age and the mother of eleven children. For nine years past she has been flooding at least twenty days in each month, with constant pain in the lower abdomen, which has been intense for the past two years. When seen by the writer some months ago she could not lie in a recumbent position and breathing was difficult, vomiting being also very frequent. Upon examination a large mass was detected in the pelvis, intimately associated with the





uterus; it was impossible also to pass a sound in the uterus. The latter organ was much enlarged but freely movable. Both ovaries were enlarged, the left more so. A complete hysterectomy was subsequently performed, the patient living but twenty-four hours thereafter. Examination of the specimen removed showed that the uterus had undergone a calcareous degeneration; a large calculus was found in the body of the uterus, accompanied by a number of smaller ones, many being like grains of sand; the interior of the uterus felt sandy, the latter being so numerous. Several cysts were connected with each other, being part of the uterus, each cyst containing from one to ten calculi. A calculus about two inches in length was also found in the left ovary. A fibromyoma about four inches long, not cystic, was also a part of the uterus.

#### Uretero-Vaginal and Uretero-Abdominal Fistulas.

Dr. Ferguson (Amer. Jour. of Med. Science) collected sixty-five cases of the above disease, and observed two himself, making sixty-seven cases in all. Of this number sixty were uretero-vaginal, four uretero-uretine, and three uretero-abdominal. This does not include fistulæ from the kidneys, nor the uretero-lumbar and uretero-inguinal varieties. No cognizance was taken by the author of the various primary operations performed on patients' accidentally injured ureters while operating upon the pelvic organs. The ages of the patients varied from nineteen to sixty-four years, excluding those persons having the congenital forms.

After dwelling upon the etiology, some of the operations,

and results, the author concludes:

1. The left ureter is more frequently the seat of trouble than the right.

2. The most frequent variety is the uretero-vaginal, and

the rarest is the uretero-abdominal.

3. The most common cause is difficult labor, and forcepsdelivery is a prominent etiologic factor.

4. Of all the operations performed in the pelvis, vaginal hysterectomy is the most frequent cause of ureteral fistula.

5. Other conditions being favorable, all cases of ureteral fistula are curable by operation: (a) In all cases of ureterovaginal fistulæ the direct method of operating should be selected, and no particular operator's method is applicable to all cases. When the ureteral opening is situated close to the bladder, Schede's operation is the most surgical, and is applicable to the greater number of cases; when situated far away from the bladder, a plastic operation may be tried before a graver and more mutilating procedure is thought of. Intraperitoneal operations are suitable for abdominal fistulæ.

6. For the cure of uretero-vaginal fistula, hysterectomy, nephrectomy, and colpocleisis are, in the author's opinion, entirely unjustifiable procedures. When septic infection of the kidney occurs it may be necessary to open or remove it. It bespeaks lack of surgical ability to remove a kidney, a uterus, or close a vagina in these cases of simple fistulæ.

7. Another procedure which the writer thinks uncalled for is transplanting of the cervix uteri into the bladder for the treatment of uretero-uterine fistula, for it causes sterility, and the menstrual flow is abnormally directed; and, besides, a disturbed bladder might cause a backward flow of urine into the uterus, Fallopian tubes, or even peritoneal cavity, depending upon the condition of the organs.

8. Directing the urine into the bowel is only justified when any other operation cannot be performed. While ureteroenterostomy has been successfully performed, it has but little

to recommend it on general principles.

#### Peritoneal Adhesions.

Nove-Josseraud and Goinard (Lyons Med.) relates three cases in young women on whom operations on the internal genitals were succeeded by pain which continued until a second abdominal operation was performed, and division of the peritoneal adhesions was followed by the relief of pain. The authors give a general account of peritoneal adhesions that cause pain, usually due to inflammation of one of the abdominal viscera. They may be set up by laparotomy, but it does not appear probable that contusion of the abdomen, apart from the inflammation, has, as Reidel has suggested, set up intraperitoneal adhesions. In addition to giving rise to acute and chronic intestinal obstruction, adhesions may cause much pain. The character of the pain is variable; it may be fixed in position and continuous, and not preserve any relation to intestinal movements, or it may be intermittent, resembling colic and preceding defecation, after which physiological act it is relieved for a time. Adhesions may also become more painful during menstruation. By interference with the intestines they may produce constipation, and when attached to the bladder they may give rise to cystitis and dysuria. With regard to operative interference, the diagnosis being difficult, the adhesions are sometimes only discovered on opening the abdomen. Against the objection that operation itself is likely to give rise to fresh adhesions, it is suggested that after operation the intestines should be kept in active peristalsis by purgatives and enemata. In pelvic adhesions the Trendelenhurg position will be found useful.

## Obstehrics.

#### Cause of Extrauterine Pregnancy.

Dr. Strassman (Berlin. klin. Wochenschrift): This condition occurs when the impregnated ovum is retarded in its passage through the tube to the uterus. The ovum settles in some portion of the Fallopian tube, where it becomes surrounded by the chorionic villi. Among some of the factors bringing about this condition, may be mentioned: A previous catarrhal inflammation of the epithelium, with destruction of the latter; formation of strictures; infiltration of the walls; the pocketing and isolation of a portion of the tube; this latter condition, with a diminution of the lumen, is one of the most common conditions found. Peremetritis is also instrumental in its causation. Developmental errors in the tube's formation act as a predisposing cause; as hernia, diverticula, accessory ostia or tubes. Finally extrauterine pregnancy may occur if the product of conception is too large for the canal or if there occurs a change in its consistency. Slowed propulsion, abnormal length of the tube, the wandering of the germ from the other ovary, or primary abnormality of the ovum, and the blocking up of the channel by a profuse hemorrhage from rupture of a follicle, all may act as predisposing factors.

#### Pain and Menstrual History of Extrauterine Pregnancy.

Dr. Cooke Hirst (Jour. of Obst.): There are three cardinal symptoms of ectopic gestation: Pain, characteristic in nature, manner of occurrence, and situation; irregularity of menstruation, often with the discharge of what the patient calls "pieces of flesh" (decidua); and these physical signs: for the first two, three or four weeks a small swelling in the tube, no bigger than the end joint of one's thumb, and unadherent; later an exquisitely sensitive mass fixed in the pelvis by thick, velvety adhesions. He presents tabulated histories of his cases for the purpose of disproving the statement in a recent English monograph, which has been copied in a text-book, that pain is not a symptom of this condition. He states the pain is described by the patient in strongest terms; occurring in paroxysms with intervals free from suffering; appearing at any time from a few days or months after a normal menstruation; situated often in one groin, though frequently indefinitely referred to the lower abdomen; extending down one leg or up to the epigastrium; and pain so severe as to occasion profound systemic disturbance—syncope followed by nausea and vomiting, a cold sweat, hysterical outbreaks, complete disability, and every appearance of excessive shock, and these symptoms do not necessarily indicate rupture of the sac and internal bleeding.

In regard to the menstrual history one is struck with the fact (in his cases) that it is irregular and often there has been no cessation at all. Prolonged uterine bleeding, preceded or followed by the discharge of decidua, is the almost universal rule at some period in the history of a tubal pregnancy.

#### Eclampsism, or Puerperal Eclampsia without Convulsions.

At a recent meeting of the Obstetrical Society of France there was an interesting discussion on a condition that M. Bar proposes to call "eclampsisme." In eclampsia, says Bar, the occurrence of convulsions is a capital feature, and it aggravates the prognosis very decidedly, but what needs to be known is the fact that there are a good many cases in which no convulsions take place, but instead the patient is attacked by very intense neuraligia, mania, diarrhea, or some other striking symptom. Such cases may prove fatal, and that speedily. Bar seems to have been the first to take cognizance of this condition, but his remarks on the occasion in question were called forth by the histories of two cases reported at the meeting by Budin.

Budin's first case was that of a primipara, aged thirty-one years, who had arrived at term and was brought to the Maternity Dec. 16, 1897. She had prodromes of eclampsia, and there was a notable amount of albumen in her urine. She also had gastralgia, headache, disturbance of vision, and a cerebral condition which Budin simply called "singular," without describing it. She was delivered spontaneously of a living child, and the delivery was followed by hemorrhage which, although the amount of blood lost did not exceed twenty-five ounces, called for artificial removal of the placenta. After this the prodromes of eclampsia became more pronounced, her general condition grew worse, and in spite of every care, she died in seven hours, without having had a convulsion. At the post-mortem examination the charactertistic renal lesions were found, and the liver presented ecchymotic spots having the geographical contours seen in cases of eclampsia.

The second patient was also primipara, who continually had "oppression." At the time of her entering the Clinique Tarnier, March 15th, she had albumen in the urine, visual disturbances, etc. She was considered to be in imminent danger of eclampsia, and was treated accordingly. She was delivered a week later without having had a convulsion, although at

every instance one was expected to occur. The placenta showed patches of atrophy and numerous hemorrhages, some old and others recent. This woman recovered.

It is of very great importance, says Budin, to observe the premonitory symptoms of eclampsia. Patients may have self-intoxication, he continues, and be found in a real state of cclampsia, without having any convulsive attack. Formerly, he adds, convulsive seizures were looked upon as the characteristic mark of eclampsia; they are still the cardinal feature in the majority of cases, but they are only one among numerous symptoms of self-intoxication; they are the most striking, but the others should not be overlooked, either from the diagnostic or from the therapeutical point of view.

An interesting contribution to the casuistics of the condition was made by Demelin, who related the case of a woman who had all the premonitory symptoms of eclampsia, but no convulsions. Jaundice soon supervened, however, with hematuria and hemorrhage from the nose and the gums, so that the diagnosis of icterus gravis was made. The jaundice and the hemorrhages ceased at the same time, and the patient recovered.

We can hardly doubt that Bar has drawn attention to a phase of the perils of childbirth which, if it has not been altogether overlooked heretofore, has at least not been generally appreciated. By so doing, he has certainly performed a service far greater than that resulting from the most of the new operations that are invented in such profusion.—N. Y. Medical Journal.

#### Primary Treatment of Post-Partum Hemorrhage.

Dr. Curran (Med. Record): After carefully discussing the various methods employed and suggested by authorities for the primary arrest of post-partum hemorrhage, the author advocates the compression of the abdominal aorta with the ulnar surface of the closed left hand, compressing the aorta against the spine. He maintains that the pressure should be continued until all bleeding has ceased, thus allowing time for clots to form in the mouths of the uterine sinuses and for muscular contractility to have returned. Not until this has been accomplished are the secondary measures, such as ergot, douche or tamponade, indicated.

#### Periodic Menstrual Psychoses.

Dr. Trenel relates a case of delirum with hallucinations occurring at the menstrual periods in a woman thirty-seven years of age who had given birth to a child some years previously. The attacks took place in January, March, April and May, 1896, and on the two last occasions were followed by melancholic depression lasting for a few days. Such cases are

rare, but may be met with in either early, late or middle menstrual life; and may be acute, subacute or chronic. The intervals between the menstrual periods are generally free from mental symptoms. The prognosis is relatively favorable, 68 per cent ending in cure, but the condition may become chronic, or may be followed by dementia, or may be transformed into ordinary insanity. When there are co-existing lesions of the genital organs, removal of the ovaries may be indicated, and may sometimes give good results, but recourse to operation should be had only after a long period of observation. Treatment in the attacks should usually be carried out at home, and not in an asylum.

#### Cysticercus Cellulose in the Milk.

Dr. Gundellach reports, in the Zeitsch. f. Fleisch- u. Milchhygiene, Vol. VII, p. 119, the finding of seven cysticercæ in the milk of a hog. This is the only case thus far reported of the finding of the parasite in the milk.

#### NOTES.

#### THE SWEETWATER HOTEL.

Physicians returning from the east are loud in their praise of a new summer resort which has just opened to the public in Massachusetts, on the property of Dr. W. R. Hayden, at Bedford Springs, who is so well known to the profession of the country through his viburnum compound. This new hotel is situated in a region surrounded by so many places of historical interest as to make it well worth one's time to visit it, and the accommodations are of the highest order.

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Fig. XVII-Dorsal Position.

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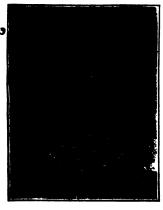
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